ROSE HILL SCHOOLS
USD 394

BENEFIT GUIDE

Effective October 1, 2025

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We recognize employee benefits are important to you and are committed to providing a choice of comprehensive and affordable plans. This Benefit Guide was created to help you understand our benefit plans. Please take time to review each plan, so you can choose the plans best for you.

Please note that AFLAC will no longer be offered as part of this enrollment. However, if you currently have AFLAC coverage, you may choose to grandfather your existing plan, please contact HR.

If you have any questions regarding our employee benefit plans, please do not hesitate to reach out to the Central Office for support.

Chuck Lambert
Superintendent

Employee Benefit Website

You can access the employee benefit website 24/7!

https://c2mb.ajg.com/usd394rosehill/home/

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 39-40 where Notice of Creditable Coverage begin for more details.

USD 394 Rose Hill provides a wide range of benefits for you and your dependents. You are encouraged to evaluate your needs before enrolling or declining to participate in any of the benefit plans offered.

This Benefit Guide contains a brief overview of some of the important elements of the benefit plans sponsored by USD 394 Rose Hill. This guide is not intended to be a Summary Plan Description (SPD), which will be provided to you when you actually enroll in a plan and is also available on the School District's Benefit Website: www.usd394benefits.com

The terms of the plan document will govern each plan. In the event of a conflict between this benefit guide and the plan document, the plan document will prevail. Each plan may be amended or terminated at the sole discretion of USD 394 Rose Hill. Nothing in this Benefit Guide is intended to guarantee employment with USD 394 Rose Hill.

If you do not enroll at your first opportunity, limitations may apply and you may only be allowed to enroll in the plan during the 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 end of the plan year, unless you terminate employment or have a qualifying life event.

Contact Gallagher Benefit Services at (316) 977-9779 with questions.

Welcome

Who is Eligible?

Employee

All active employees working 30 or more hours per week, are eligible to enroll in the group insurance plans described in this Benefit Guide. New employees are eligible the first of the month following date of hire.

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.

Qualifying Life Events

After your initial eligibility date or the annual open enrollment period, you may only change your benefit election within 30 days following a Qualifying Life Event. A Qualifying Life Event includes:

- 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;
- Employee or spouse's eligibility for Medicare.

Healthcare Reform

Due to Healthcare Reform:

- The individual mandate became effective on 01/01/2014
- After tax year 2019, 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:

- If you are eligible for benefits at USD 394 Rose Hill and buy coverage through a Federal or State Exchange, you and your family will not qualify for a subsidy through the Exchange.
- 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.

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.

Your health plan has negotiated fee discounts with some health care providers. These providers have several names including contracting providers, preferred providers, network providers or participating providers. The contracting providers discounted price is called the "allowed amount". When you receive your health care from contracting providers, you will receive the highest benefits allowed by your plan. In addition, the contracting providers agree not to balance bill you the amount of the discount. It is your responsibility to verify your providers are contracting providers for your health plan.

Non-contracting providers set their own fees and do not offer a discounted fee to your health plan. Their fees are usually higher, sometimes much higher, than your health plan's allowed amount. Non-contracting providers will also require you pay the difference between their fee and the health plan's allowed amount. This difference can be substantial and may not satisfy your deductibles, coinsurance, copays or out of pocket limits shown in this guide.

If you have questions about contracting providers or your benefits, contact your claims payer or insurance company for more information.

***Note: If you have a qualifying life event and are canceling benefits already paid for, you must notify HR ten (10) business days prior to the start of your new coverage to be reimbursed for premiums already taken from your check.**

Open Enrollment Online Instructions

→ **ALL EMPLOYEES ARE REQUIRED to log in & complete the online enrollment even if you waive all of the benefits.**
→ **If you are covering a Spouse and/or Children, you will need to have their Dates of Birth and Social Security Numbers.**

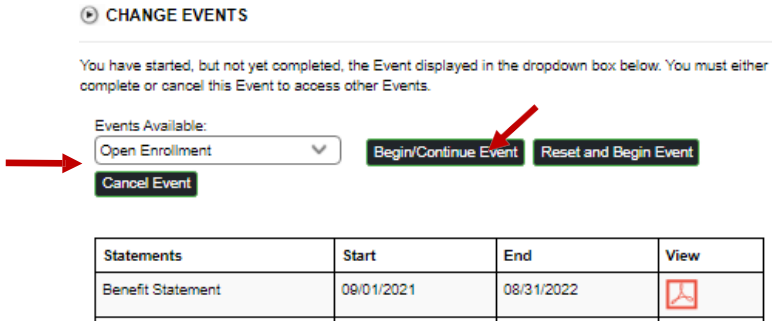
1 Login to ARCORO/INFINITY HR site

- Go to https://identity.arcoro.com/Account/Login
- **Choose the box on the left (Benefits) and click the arrow**
- Log In with your User ID and Password.
- If you don't remember it, click "Forgot your password/username"

*To access this system, you must have a valid account created for you and have a valid email address on file.

2 Homepage

- Review Homepage
- Under Change Events, the dropdown should say "Open Enrollment.".
- Click "Begin Event"



3 Complete Enrollment

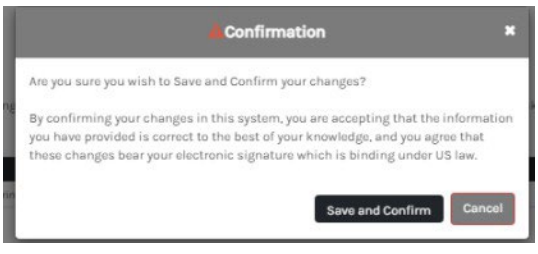
- Click through both Authorization screens.
- Confirm info for yourself and then for your spouse and/or children.
- Go through each benefit screen by clicking "SAVE & CONTINUE" once your elections have been made.

4 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".

5 Review and Confirm

- Review information on Review Step. If you selected a benefit that requires Evidence of Insurability (EOI), you will need to print, complete and return the form to HR.
- Click "Save & Continue" button to confirm your enrollment. A popup will appear asking if you are sure.
- On the next page, you can Print Confirmation Statement.
- You can log in & make changes until the close of Open Enrollment.



***NOTE:** If you are enrolled in any of the grandfathered plans including American Fidelity Cancer, Met Life Long Term Care or Texas Life, you will need to contact HR to make any changes or terminations. Changes made through the online enrollment system will not apply to those plans.*

Medical Plan Information

IMPORTANT UPDATE:

If an employee has dependent(s) (spouse and/ or children up to age 26) that are also employed by the district, and eligible to receive their own benefits, the district will take an additional **$415** off for the employed dependent(s) if employee elects to do employee + spouse, employee + children, or employee + family. Contact Human Resources if you have any questions.

Medical Plan Provider Networks

When selecting your medical plan for the 2025 - 2026 plan year, you will first need to select a network. There are two networks to choose from:

- **Open Network:** Includes all contracting Hospitals and Facilities
- **Wesley Preferred Network:** Excludes Ascension Via Christi Hospital and Facilities

The medical plans are the same regardless of the network you choose. The premiums for the plans in the Wesley Preferred Network will be lower, however, Ascension Via Christi Hospitals and Facilities are excluded. It is important for you to verify each of your medical providers are "contracting providers" in the network you select. If you use an out-of-network provider, your costs will be substantially higher. For instance, if you choose the Wesley Preferred Network and you use an excluded Ascension Via Christi facility, that would be considered Out-of-Network. You will be responsible for any additional charges that would apply.

WESLEY PREFERRED

The Preferred Network excludes Ascension Via Christi Providers and Facilities.

The following facilities are excluded and are considered OUT-OF-NETWORK:

- All Via Christi Hospitals & Clinics
- All primary & specialty** physicians
- Via Christi Clinic Independent Laboratory
- Via Christi Immediate/Urgent Care Clinics
- Via Christi Clinic Day Surgery
- Via Christi Sleep Medicine Center
- Via Christi Surgery Center - Founders' Circle
- Via Christi Clinic Diagnostic services
- Via Christi Rehab Hospital
- Kansas Surgery & Recovery
- Kansas Spine/Kansas Heart Hospital
- Via Christi Outpatient Therapy Clinics
- Kansas Medical Center
- Rock Regional Hospital

****These Via Christi Specialties will remain IN NETWORK on the Preferred Network since there are limited alternatives in the community:**

- Audiology
- Otolaryngology/ENT
- Dermatology/Dermatopathology
- Endocrinology & Diabetes
- Rheumatology
- Anesthesiology & Certified Nurse Anesthetists
- Allergy & Asthma (including Pediatrics)
- Gastroenterology (including Peds)
- Neurology (including Peds)

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.

Medical Plans

	Option 1 – OPEN $2,500 Plan
Primary Care Physician Selection and Referrals are NOT REQUIRED.	
Deductible **(Plan Year: Oct 1 - Sept 30)**	$2,500 Individual $5,000 Family
Coinsurance	50%
Out of Pocket Maximum **(Includes Deductible & Copays)**	$4,000 Individual $8,000 Family
Primary Physician Office Visits **(Including Walk In Clinics)**	$30 Copay
Specialist Office Visits	$70 Copay
Telemedicine Visits	Non-Specialist: $30 Copay; Specialist: $70 Copay
Lab, X-ray & Diagnostic Testing	Deductible & Coinsurance If performed as a part of a physician office visit & billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.
Preventive Services **Eye Exam (1 exam per 12 months)**	100% as required by Health Care Reform 100% Covered
Mental Health: Inpatient **Mental Health: Outpatient**	Deductible & Coinsurance $70 Copay
Urgent Care Center **Hospital Emergency Room**	$30 Copay $250 Copay + Deductible & Coinsurance
Hospital: Inpatient/Outpatient	Deductible & Coinsurance
Spinal Manipulation (modalities are an additional cost)	$20 Copay; no deductible
Retail Prescription Drugs Value Drugs Tier 1A Preferred Generic Preferred Brand - Name Drugs Non - Preferred Generic/Brand Specialty Drugs Preferred Non-Preferred	 $3 Copay $10 Copay $45 Copay $70 Copay 20% up to max $150 Copay 20% up to max $250 Copay
	Option 1 - OPEN $2,500
MONTHLY Deductions Employee Only Employee & Spouse Employee & Child(ren) Family	 $488.83 $1,528.21 $1,257.03 $2,070.49
SEMI-MONTHLY Deductions Employee Only Employee & Spouse Employee & Child(ren) Family	 $244.42 $764.11 $628.52 $1,035.25

Medical Plans

	Option 2 – OPEN $5,000	Option 3 - WESLEY PREFERRED $5,000
Primary Care Physician Selection and Referrals are NOT REQUIRED.		
Deductible **(Plan Year: Oct 1 - Sept 30)**	$5,000 Individual $10,000 Family	
Coinsurance	20%	
Out of Pocket Maximum **(Includes Deductible & Copays)**	$6,850 Individual $13,700 Family	
Primary Physician Office Visits **(Including Walk In Clinics)**	$5 Copay	
Specialist Office Visits	$65 Copay AFTER DEDUCTIBLE	
Telemedicine Visits	Non-Specialist: $5 copay Specialist: $65 Copay AFTER DEDUCTIBLE	
Lab, X-ray & Diagnostic Testing	Deductible & Coinsurance If performed as a part of a physician office visit & billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Preventive Services **Eye Exam (1 exam per 12 months)**	100% as required by Health Care Reform 100% Covered	
Mental Health: Inpatient **Mental Health: Outpatient**	Deductible & Coinsurance $65 Copay	
Urgent Care Center **Hospital Emergency Room**	$30 Copay $200 Copay + Deductible & Coinsurance	
Hospital: Inpatient/Outpatient	Deductible & Coinsurance	
Spinal Manipulation (modalities are an additional cost)	$5 Copay; no deductible	
Retail Prescription Drugs Value Drugs Tier 1A Preferred Generic* Preferred Brand - Name Drugs* Non - Preferred Generic/Brand* Specialty Drugs Preferred Non-Preferred	 $3 Copay $12 Copay $50 Copay AFTER DEDUCTIBLE $75 Copay AFTER DEDUCTIBLE 20% up to max $250 Copay AFTER DEDUCTIBLE 20% up to max $500 Copay AFTER DEDUCTIBLE	
	Option 2 - OPEN $5,000	**Option 3 - WESLEY PREFERRED $5,000**
MONTHLY Deductions Employee Only Employee & Spouse Employee & Child(ren) Family	 $228.83 $969.25 $776.07 $1,355.52	 $187.43 $880.21 $699.46 $1,241.65
SEMI-MONTHLY Deductions Employee Only Employee & Spouse Employee & Child(ren) Family	 $114.42 $484.63 $388.04 $677.76	 $93.72 $440.11 $349.73 $620.83

***IMPORTANT Rx Information:**

The deductible is waived for drugs on Aetna's Chronic Medicine List, so only the copay would apply.

The deductible is also waived for generic and brand drugs so only the copay would apply.

A full list of these drugs is available on Aetna's member site.

Medical Plans

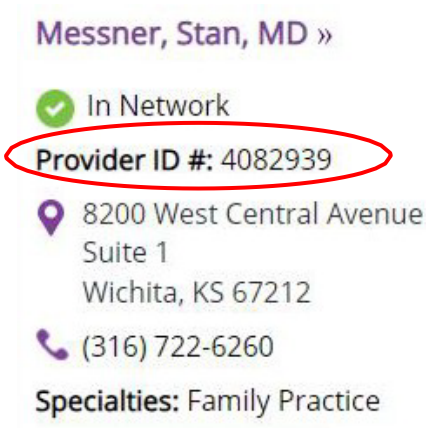
	Option 4 - WESLEY PREFERRED $6,500 Plan
Primary Care Physician Selection and Referrals are ARE REQUIRED.	
Deductible (Plan Year: Oct 1 - Sept 30)	$6,500 Individual $13,000 Family
Coinsurance	50%
Out of Pocket Maximum (Includes Deductible & Copays)	$9,100 Individual $18,200 Family
Primary Physician Office Visits (Including Walk In Clinics)	$20 Copay
Specialist Office Visits	$65 Copay AFTER DEDUCTIBLE
Telemedicine Visits	Non-Specialist: $20 Copay; Specialist: $65 Copay AFTER DEDUCTIBLE
Lab, X-ray & Diagnostic Testing	Deductible & Coinsurance If performed as a part of a physician office visit & billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.
Preventive Services **Eye Exam (1 exam per 12 months)**	100% as required by Health Care Reform 100% Covered
Mental Health Inpatient: **Mental Health Outpatient:**	Deductible & Coinsurance $65 Copay
Urgent Care Center **Hospital Emergency Room**	$100 Copay $300 Copay + Deductible & Coinsurance
Hospital: Inpatient/Outpatient	Deductible & Coinsurance
Spinal Manipulation (modalities are an additional cost)	$5 Copay; no deductible **Requires a referral from your PCP**
Retail Prescription Drugs	
Value Drugs Tier 1A	$3 Copay
Preferred Generic*	$12 Copay
Preferred Brand - Name Drugs*	$50 Copay AFTER DEDUCTIBLE
Non - Preferred Generic/Brand*	$75 Copay AFTER DEDUCTIBLE
Specialty Drugs	
Preferred	20% up to max $250 Copay AFTER DEDUCTIBLE
Non-Preferred	20% up to max $500 Copay AFTER DEDUCTIBLE

	Option 4 - WESLEY PREFERRED $6,500
MONTHLY Deductions	
Employee Only	$62.79
Employee & Spouse	$612.24
Employee & Child(ren)	$468.89
Family	$898.91
SEMI-MONTHLY Deductions	
Employee Only	$31.40
Employee & Spouse	$306.12
Employee & Child(ren)	$234.45
Family	$449.46

If you select Option 4 - WESLEY PREFERRED $6,500 Plan, you will be required to designate a Primary Care Physician (PCP) and enter their Aetna PROVIDER ID # when you complete your online enrollment. You will be required to do this for everyone covered on the plan. You can access the contracting provider list for this plan by following the directions on page 8.

Note: Nurse Practitioners and Physician Assistants cannot be designated as a Primary Care Provider. You will need to list the physician in which they practice under.

EXAMPLE:



If the Provider ID is missing, that PCP is not eligible for selection.

* IMPORTANT Rx information: The deductible is waived for drugs on Aetna's Chronic Medicine List, so only the copay would apply
The deductible is also waived for generic and brand drugs so only the copay would apply. *A full list of these drugs is available on Aetna's member site.*

Medical Plan Information

Provider Networks

It is important for you to verify that providers and facilities contract with your network, prior to each service. If you choose to receive your medical care from a non-contracting provider, the amount you will pay can be substantially more than if you receive services from a contracting provider**.**

Find Contracting Providers:

1. Go to **www.aetna.com**
2. Click "Find a Doctor" and under "Guests" select "Plan from an employer"
3. Under "Continue as a Guest", enter your location (zip code, city, county, or state) and then click Search
4. Under "Select a Plan" enter the plan name to narrow the list or scroll down until you see the desired network. Plans are subcategorized with different headers. Use the chart below:

5. After selecting the correct plan, you can search or select a category (ex. Primary Care Physician or Urgent Care).

OPEN NETWORK Option 1 - $2,500	Under: "Aetna Standard Plans" Choose: "Open Choice PPO"
OPEN NETWORK Option 2 - $5,000	Under: "Aetna Standard Plans" Choose: "Open Choice PPO"
WESLEY PREFERRED Option 3 - $5,000	Under: "Kansas & Missouri Preferred Networks" Choose: "Wesley Preferred Open Choice PPO"
WESLEY PREFERRED Option 4 - $6,500	Under: "Kansas Connector Networks" Choose: "Kansas Connector Preferred Managed Choice"

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.

Medical Plan 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 **"2025"** as the plan year; Select **"Advanced Control Plans - Aetna"**
3. Click "Search to see if drug is covered" and search prescription drug name or open the **Aetna Drug Guide.**
4. To access Aetna's **Chronic Medicine List** or **Preventive Medicine List**, click "**2025 other plan information**" under "**More Coverage Details**"

Note: The **Preventive Medicine List** applies to the High Deductible Health Plan; The **Chronic Medicine List** applies to Non-High Deductible Health Plans.

Generic Drugs: Generic drugs are identical to brand-name drugs in dosage, safety, strength, quality and performance. Generics have the same active ingredients. Inactive ingredients such as color or flavor may be different. This means you can save money without sacrificing quality because the cost of generic drugs is much less than brand-name.

Brand Name Drugs: Brand-name 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. Brand-Name drugs cost more than generic drugs.

Specialty Drugs: Medications used to treat complex or rare conditions that you may need to get from a Specialty Pharmacy.

Step Therapy: When you try one or more medications before the plan will approve coverage for a different one.

Prior Authorization: When your medication requires approval by the plan before the medication can be covered.

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 CVS Caremark Home Delivery order arrives.

Prescription #2: Is typically for a 90-day supply (with three refills). Send this one to CVS Caremark 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 the number on your ID Card
- 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.
- Doctor—Your doctor can send an electronic prescription using e-prescribe or by logging in to the provider portal on Availity.com.

Visit the Aetna member site for more information.

Medical Plan Information

Telemedicine - Teladoc

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.

Simple Steps - Online Health Assessment

COMPLETE YOUR HEALTH ASSESSMENT

- **Login to your secure member website at www.aetna.com.** You will need to register by creating a user name and password, if you have not already.
- On the home page, click on **"Health & Wellness"** and then **"Access Wellness"**
- To access your Health Dashboard, click on **"Complete a Health Assessment"** and go to **"Launch my Health Assessment"**

After completing your health assessment, you'll receive a health report that gives you:

- A risk score – Compare it with others who completed the health assessment.
- Your top strengths – Shows what you're doing right and why doing these actions are important.
- Your top health risks – Tells you where you can improve and why you need to take action.
- Health risk grid – Lets you see how you're doing across 15 different health categories.

You are able to update your Health Assessment at any time with updated results!

Medical Plan Information

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

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

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 Maternity Program

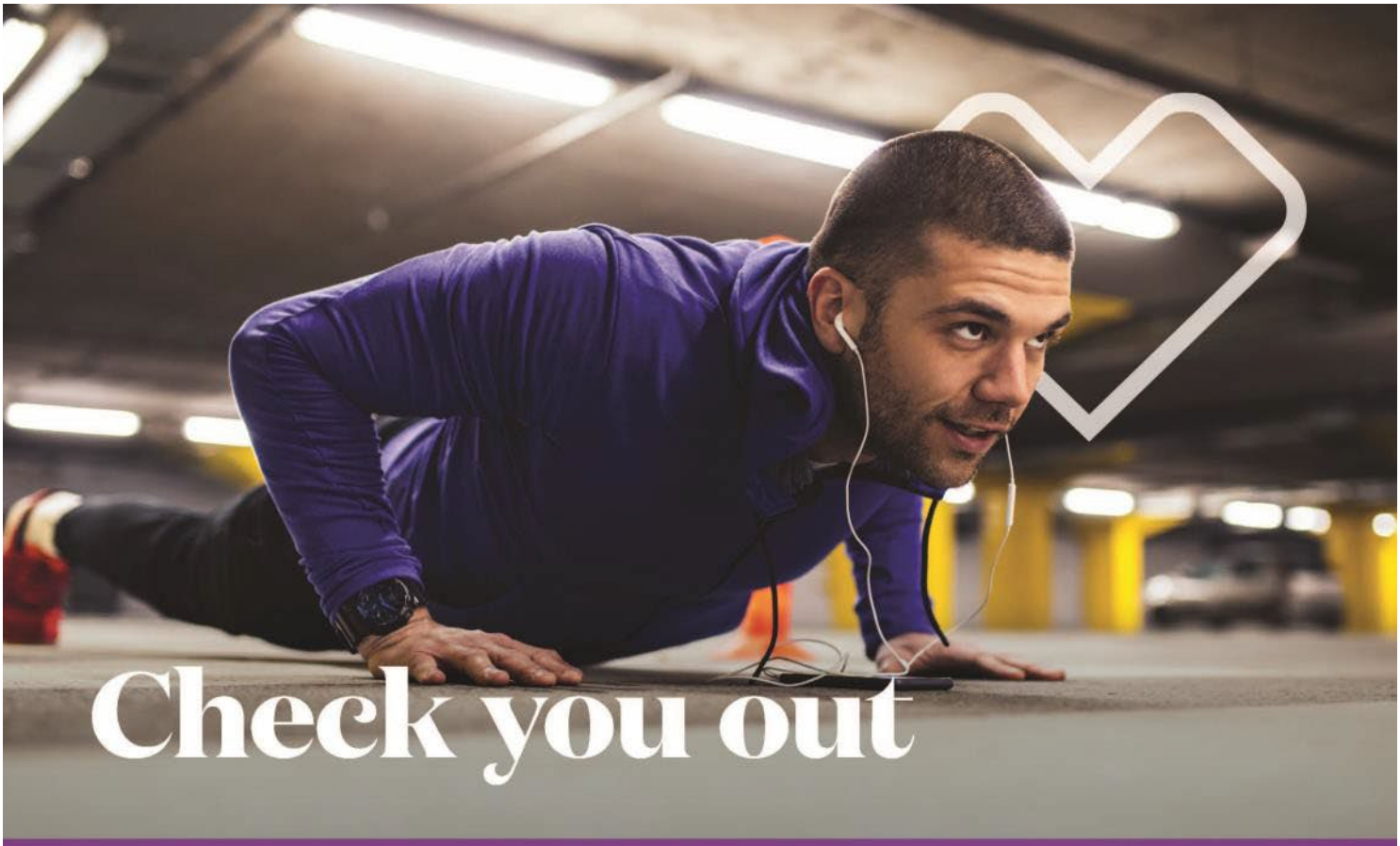
This program helps members give their babies a healthy start. You'll learn about what to expect before and after delivery, early labor symptoms, newborn care and more.

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 postdelivery, it is personalized for you.

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

Medical Plan Information



Better health starts here

Check in with yourself

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

Taking a health assessment can help you:

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

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

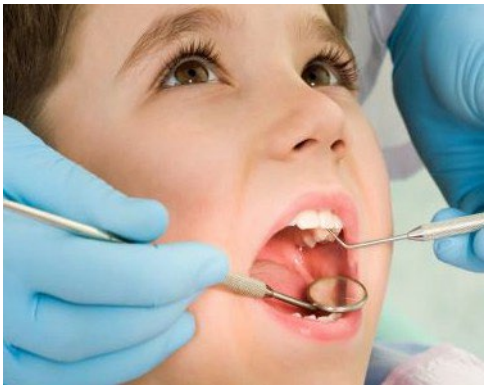
Aetna.com

97.03.347.1 (1/21)

aetna®

Dental Plan

INCLUDED IN YOUR DENTAL PLAN:



1. **Right Start 4 Kids (RS4K)**
   The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage, with no deductible, for all services covered under the plan, excluding orthodontics, when an in-network dentist is seen.
   **If an out-of-network dentist is seen, the underlying contract applies.*

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

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

Find a Dentist

TO FIND CONTRACTING DELTA DENTAL PROVIDERS:

1. On the internet, go to: **www.deltadentalks.com**
2. Click on "Find a Dentist"
3. Select the "Specialty" and under "Your Plan", select "Delta Dental Premier"
4. Click "Find Dentists"

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.

DELTA DENTAL

This summary assumes eligible dental services are provided by contracting providers.
If you receive dental services from a non-contracting provider, the benefits will be substantially less. See the plan document for more information.

Dental Plan

Our Delta Dental plan is a PPO plan using the Delta Premier Network. When you receive services from a contracting dentist, you will receive the highest level of benefits allowed by the plan. You can look up the contracting dentists by visiting: **www.deltadentalks.com**

If you receive dental services from a non-contracting dentist, Delta Dental will place a limit on the allowed amount. You will be responsible for all the expenses over the allowed amount. You will minimize your out of pocket expenses by using dentists who contract with the Delta Premier Network. Referrals are not necessary for dental treatments.

MAXIMUM	**$1,500.00 per person per calendar year.**	
PREVENTIVE	**No Deductible - 100% Payment** Oral examinations - two times per Calendar year Diagnostic x-rays - bitewings two times per Calendar year for dependents under age 18 - bitewings once every 12 month for adults age 18 and over - full mouth once each 5 years Prophylaxis (Cleanings) - unlimited per Calendar year Fluoride applications - two times per Calendar year up to age 19 Space Maintainers - dependent children under age 14 Sealants - one per lifetime for dependents under age 16	
DEDUCTIBLE	$25.00 per person per calendar year $75.00 maximum per family per calendar year Basic & Majors Services are combined to meet the deductible	
BASIC SERVICES	**After Deductible - 80% Payment** Emergency exam by the dentist for treatment of pain Oral surgery - provides for extractions Regular Restorative - composite restorations on all teeth Endodontic - root canals Periodontics - treatment of diseases of the gums	
MAJOR SERVICES	**After Deductible - 50% Payment** Individual crowns Prosthodontics - includes bridges and dentures	
DEPENDENTS	Married or unmarried dependents covered up to age 26.	
Deductions	**MONTHLY**	**SEMI-MONTHLY**
Employee Only	$35.26	$17.63
Employee & Spouse	$69.79	$34.90
Employee & Child(ren)	$68.85	$34.43
Family	$117.02	$58.51

Right Start 4 Kids: Children 12 & under have 100% coverage (no deductible) for all services covered under the plan.

Comprehensive Vision Plan - Option 1

Services	In Network Member Cost	Out of Network Allowances
VISION EXAM	$10	$35
CONTACT LENS FIT & FOLLOW-UP	*Contact lens fit & 2 follow-up visits are available once a comprehensive eye exam has been completed	
STANDARD - spherical clear contact lenses in conventional wear & planned replacement (e.g. disposable, frequent replacement, etc.)	$0	$40
PREMIUM - all lens designs, materials & specialty fittings other than Standard Contact Lenses (e.g. toric, multifocal, etc.)	10% off Retail, then apply $55 Allowance	$40
FRAMES - any available frame at provider location	$130 Allowance	$65
STANDARD PLASTIC LENSES		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$40
Trifocal	$25 Copay	$55
LENS OPTIONS		
Standard Polycarbonate	Adults: $40 Copay Dependents under 19: $0	$25
UV Coating	$15 Copay	Not Covered
Tint (Solid & Gradient)	$15 Copay	
Standard Scratch-Resistance	$15 Copay	
Standard Anti-Reflective Coating	$45 Copay	
Standard Progressive (Add-On to Bifocal)	$65 Copay	
Premium Progressive	$65 Copay + 80% of Retail less $120	
Other Add-Ons & Services	20% off Retail Price	
CONTACT LENSES (contact lens allowance includes materials only)	*Allowance not available if eyeglass lenses are elected	
Conventional	$130 Allowance, 15% off balance over $130	$100
Disposable	$130 Allowance	$100
Medically Necessary	$0	$200

All services are available once every 12 months.
Service frequencies are computed by date of service, not calendar year.

This summary assumes eligible vision services are provided by contracting providers.
If you receive medical services from a non-contracting provider, the benefits will be substantially less. See the plan document for more information.

Materials Only Vision Plan - Option 2

Materials Covered	In Network	Out of Network
FRAMES, LENS & OPTIONS PACKAGE Any frame, lens, & lens options available at provider locations	$200 Allowance for frame, lens & lens options, 20% off balance over $200	$100
CONTACT LENS (in lieu of frames, lens & options package)	$200 Allowance	$100

All services are available once every 12 months.
Service frequencies are computed by date of service, not calendar year.

TO FIND CONTRACTING SURENCY PROVIDERS:

1. On the internet, go to www.surency.com and select "Surency Vision"
2. Select "Find a Provider near you"
3. Select the "Access Network"
4. Enter your location and click "Get Results"

- **If you choose a provider out of network, you will need to file a claim for reimbursement. All claims must be submitted within 6 months of the date of service.**
- **A child is eligible for coverage on both options if the child is under the age of 26.**
- **Generally, Medicare does not cover eye glasses or contact lenses.**

Deductions - OPTION 1 Exam & Materials	**MONTHLY**	**SEMI-MONTHLY**
Employee Only	$10.38	$5.19
Employee & Spouse	$21.83	$10.92
Employee & Child(ren)	$18.69	$9.35
Family	$35.01	$17.51
Deductions - OPTION 2 Materials Only	**MONTHLY**	**SEMI-MONTHLY**
Employee Only	$9.57	$4.79
Employee & Spouse	$20.07	$10.04
Employee & Child(ren)	$17.21	$8.61
Family	$33.45	$16.73

This summary assumes eligible vision services are provided by contracting providers.
If you receive vision services from a non-contracting provider, the benefits will be substantially less. See the plan document for more information.

Basic Life Insurance

The basic group life insurance program is provided at no cost for employees to ensure that all of our employees have some level of financial protection. This plan includes Accidental Death and Dismemberment benefits equal to the basic life insurance amount.

Employees
Life Insurance.....$10,000
Accidental Death & Dismemberment.....$10,000

Principals & Directors
Life Insurance.....$50,000
Accidental Death & Dismemberment.....$50,000

Superintendent & Assistant Superintendent
Life Insurance.....$100,000
Accidental Death & Dismemberment.....$100,000

Age Reduction:
Your life insurance benefits and guarantee issue amounts are subject to age reduction. At age 65, amounts reduce to 65%. At age 70, amounts reduce to 40%. At age 75+, amounts reduce to 25%. Coverage terminates at retirement.

Beneficiary:
You will need to designate a beneficiary, the person who will receive your insurance money in the event of your death. Typically, any person or entity can be named a beneficiary of a trust, will, or a life insurance policy. You should review your beneficiary designation to make sure it is up to date.

Contingent Beneficiary:
You can also name a contingent beneficiary. A contingent beneficiary is the alternative beneficiary, designated by the account holder, who is set to receive the proceeds or benefits of a financial account only if the primary beneficiary is not able to accept the benefits at the time of payment.

Additional Benefits

- Living Care/Accelerated Death Benefit
- Waiver of Premium
- Additional AD&D Benefits
- Travel Assistance
- Employee Assistance Program (EAP)
- Conversion

GUARDIAN

Voluntary Life Insurance

You can 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 must elect coverage on yourself in order to elect coverage for your spouse and/or children. If you terminate employment, you may be able to continue your coverage if you notify Guardian within 30 days of your termination.

Employee

- You may elect a coverage amount between $10,000—$500,000 in $10,000 increments, up to 5 times your annual salary.
- Upon your initial enrollment opportunity, coverage is Guaranteed Issued up to **$130,000** or up to 5 times your annual salary. Coverage amounts over $130,000 will require Evidence of Insurability (EOI);
- Accidental Death & Dismemberment is included at no additional cost;
- Benefits start reducing at age 65 and terminate at retirement.

Spouse

- If employee elects coverage, spouse may elect between $5,000—$250,000 in $5,000 increments, not to exceed 100% of employee benefit.
- Upon the initial enrollment opportunity, coverage is Guaranteed Issued up to **$50,000** (not to exceed 100% of employee benefit).
- Benefit reduction and/or terminations are based on the Spouse age.
- Benefits terminate at employee age 70 or employee retirement, whichever occurs first.
- Spouse rates are based on the employee's age.

Children

- If the employee elects coverage, they may also elect $10,000 per child and it is Guaranteed Issue for one rate.
- Unmarried children, 14 days to age 21 (to 25 if a full-time student) are covered for $10,000.

Benefit Reduction Due to Age:

Benefit amount begins reducing at age 65.

See summary for more details.

2025 Open Enrollment

Employees: Currently enrolled employees can increase coverage by $10,000 or $20,000 up to the Guaranteed Issue amount of $130,000 without completing medical questions (EOI).

Spouse: Coverage enrollments (unless initial enrollment) or increases, will REQUIRE medical questions (EOI).

**Not applicable if you have been previously declined or withdrawn from coverage.*

**Subject to salary maximums*

GUARDIAN

Voluntary Life Insurance Rates

Employee Monthly Rates

Employee Premium Table (12 Payroll Deductions Per Year)										
	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
30 - 34	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
35 - 39	$0.95	$1.90	$2.85	$3.80	$4.75	$5.70	$6.65	$7.60	$8.55	$9.50
40 - 44	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
45 - 49	$1.95	$3.90	$5.85	$7.80	$9.75	$11.70	$13.65	$15.60	$17.55	$19.50
50 - 54	$3.75	$7.50	$11.25	$15.00	$18.75	$22.50	$26.25	$30.00	$33.75	$37.50
55 - 59	$5.65	$11.30	$16.95	$22.60	$28.25	$33.90	$39.55	$45.20	$50.85	$56.50
60 - 64	$5.75	$11.50	$17.25	$23.00	$28.75	$34.50	$40.25	$46.00	$51.75	$57.50
65 - 69	$10.15	$20.30	$30.45	$40.60	$50.75	$60.90	$71.05	$81.20	$91.35	$101.50
70 - 74	$26.65	$53.30	$79.95	$106.60	$133.25	$159.90	$186.55	$213.20	$239.85	$266.50
75+	$107.35	$214.70	$322.05	$429.40	$536.75	$644.10	$751.45	$858.80	$966.15	$1,073.50

*****If the benefit amount you want to select is greater than $100,000, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.**

Spouse Monthly Rates

Spouse Premium Table (12 Payroll Deductions Per Year)										
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.28	$0.55	$0.82	$1.10	$1.38	$1.65	$1.92	$2.20	$2.48	$2.75
30 - 34	$0.32	$0.65	$0.98	$1.30	$1.62	$1.95	$2.28	$2.60	$2.92	$3.25
35 - 39	$0.48	$0.95	$1.42	$1.90	$2.38	$2.85	$3.32	$3.80	$4.28	$4.75
40 - 44	$0.72	$1.45	$2.18	$2.90	$3.62	$4.35	$5.08	$5.80	$6.52	$7.25
45 - 49	$0.98	$1.95	$2.92	$3.90	$4.88	$5.85	$6.82	$7.80	$8.78	$9.75
50 - 54	$1.88	$3.75	$5.62	$7.50	$9.38	$11.25	$13.12	$15.00	$16.88	$18.75
55 - 59	$2.82	$5.65	$8.48	$11.30	$14.12	$16.95	$19.78	$22.60	$25.42	$28.25
60 - 64	$2.88	$5.75	$8.62	$11.50	$14.38	$17.25	$20.12	$23.00	$25.88	$28.75
65 - 69	$5.08	$10.15	$15.22	$20.30	$25.38	$30.45	$35.52	$40.60	$45.68	$50.75

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Spouse premiums are based on employee age

Dependent Children Rate

Dependent Children Rate = $2.00 monthly

Premium covers all dependent children regardless of the number of children.

Voluntary Life Insurance Rates

Employee Semi-Monthly Rates

Employee Premium Table (24 Payroll Deductions Per Year)										
	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.28	$0.55	$0.82	$1.10	$1.38	$1.65	$1.92	$2.20	$2.48	$2.75
30 - 34	$0.32	$0.65	$0.98	$1.30	$1.62	$1.95	$2.28	$2.60	$2.92	$3.25
35 - 39	$0.48	$0.95	$1.42	$1.90	$2.38	$2.85	$3.32	$3.80	$4.28	$4.75
40 - 44	$0.72	$1.45	$2.18	$2.90	$3.62	$4.35	$5.08	$5.80	$6.52	$7.25
45 - 49	$0.98	$1.95	$2.92	$3.90	$4.88	$5.85	$6.82	$7.80	$8.78	$9.75
50 - 54	$1.88	$3.75	$5.62	$7.50	$9.38	$11.25	$13.12	$15.00	$16.88	$18.75
55 - 59	$2.82	$5.65	$8.48	$11.30	$14.12	$16.95	$19.78	$22.60	$25.42	$28.25
60 - 64	$2.88	$5.75	$8.62	$11.50	$14.38	$17.25	$20.12	$23.00	$25.88	$28.75
65 - 69	$5.08	$10.15	$15.22	$20.30	$25.38	$30.45	$35.52	$40.60	$45.68	$50.75
70 - 74	$13.32	$26.65	$39.98	$53.30	$66.62	$79.95	$93.28	$106.60	$119.92	$133.25
75+	$53.68	$107.35	$161.02	$214.70	$268.38	$322.05	$375.72	$429.40	$483.08	$536.75

*****If the benefit amount you want to select is greater than $100,000, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.**

Spouse Semi-Monthly Rates

Spouse Premium Table (24 Payroll Deductions Per Year)										
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.14	$0.28	$0.41	$0.55	$0.69	$0.82	$0.96	$1.10	$1.24	$1.38
30 - 34	$0.16	$0.32	$0.49	$0.65	$0.81	$0.98	$1.14	$1.30	$1.46	$1.62
35 - 39	$0.24	$0.48	$0.71	$0.95	$1.19	$1.42	$1.66	$1.90	$2.14	$2.38
40 - 44	$0.36	$0.72	$1.09	$1.45	$1.81	$2.18	$2.54	$2.90	$3.26	$3.62
45 - 49	$0.49	$0.98	$1.46	$1.95	$2.44	$2.92	$3.41	$3.90	$4.39	$4.88
50 - 54	$0.94	$1.88	$2.81	$3.75	$4.69	$5.62	$6.56	$7.50	$8.44	$9.38
55 - 59	$1.41	$2.82	$4.24	$5.65	$7.06	$8.48	$9.89	$11.30	$12.71	$14.12
60 - 64	$1.44	$2.88	$4.31	$5.75	$7.19	$8.62	$10.06	$11.50	$12.94	$14.38
65 - 69	$2.54	$5.08	$7.61	$10.15	$12.69	$15.22	$17.76	$20.30	$22.84	$25.38

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Spouse premiums are based on employee age

Dependent Children Rate

Dependent Children Rate = $1.00 semi-monthly

Premium covers all dependent children regardless of the number of children.

Voluntary Short Term Disability Plan

How long can you go without a paycheck?

If you are like most people, you do not have enough emergency savings to miss many paychecks.

What are your chances of becoming disabled and unable to work? One in four 20 year olds today will become disabled before they retire.

You can ignore the problem, but it's hard to ignore the facts. Freak accidents are NOT usually the culprit. Back injuries, cancer, heart disease and other illnesses cause the majority of long-term absences.

If you're like most employees, you don't have the disability insurance or enough emergency savings to last 31.2 months. Yes, the average long-term disability claim lasts 31.2 months.

Guardian is offering 2 disability plans to choose from to take away the worry of not being able to work and bring home a paycheck. The district does require that you must exhaust your leave before the disability plan will pay a benefit.

Short Term Disability Plans

	Paid on	Max Weeks	Monthly Rate per $10 weekly benefit	Semi-Mo Rate per $10 weekly benefit
Option 1	*15th day*	*24 weeks*	*$0.53*	*$0.27*
Option 2	*60th day*	*17 weeks*	*$0.25*	*$0.13*

- **Benefit Amount is 60% of weekly salary**
- **Benefit Maximum is $1,000 per week**

Evidence of Insurability is not required for enrollment; however, Pre-Existing conditions from the last 3 months will not be covered for the first 6 months of the policy.

NOTE: *If you are enrolled in any of the grandfathered plans including American Fidelity or Aflac, you will need to contact HR to make any changes or terminations. Changes made through the online enrollment system will not apply to those plans.*

GUARDIAN

3in1 Supplemental Health 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 – On & Off Job (Value Schedule Type)			
Accident Emergency Treatment	$150	**Accident Follow-Up Visit Doctor**	$25 up to 6 treatments
Air Ambulance	$500	**Ambulance**	$100
Appliance	$100	**Blood/Plasma/Platelets**	$300
Burns (2nd Degree/3rd Degree)	Based on size of Burn: $0/$2,000 - $3,000/$12,000	**Burn – Skin Graft**	50% of burn benefit
Child Organized Sport	20% increase to child benefits	**Chiropractic Visits**	No Benefit
Coma	$7,500	**Concussions**	$50
Dislocations	Schedule up to $3,600	**Diagnostic Exam (Major)**	$100
Emergency Dental Work	$200/Crown $50/Extraction	**Epidural pain management**	$100, 2 times per accident
Eye Injury	$200	**Family Care**	$20/day up to 30 days
Fracture	Schedule up to $4,500	**Initial Physician's Office/Urgent Care Treatment**	$50
Hospital Admission	$750	**Hospital Confinement**	$175/day, up to 1 yr
Hospital ICU Admission	$1,500	**Hospital ICU Confinement**	$350/day – up to 15 days
Knee Cartilage	$500	**Joint Replacement (hip/knee/shoulder)**	$1,500/$750/$750
Laceration	Schedule up to $300	**Lodging**	$100/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days	**Prosthetic Device/Artificial Limb**	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days	**Ruptured Disc with Surgical Repair**	$500
Surgery (Cranial, Open Abdominal, Thoracic)	$1,000 Hernia: $125	**Surgery – Exploratory or Arthroscopic**	$150
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500	**Transportation**	$400, 3 times per accident
X-Ray	$20	***Wellness**	$50

***WELLNESS BENEFIT:** **Available once per Calendar Year and pays one $50 benefit for each covered person. This would include the employee, spouse and any covered children!**

3in1 Supplemental Health Plan

Critical Illness			
Critical Illness Benefit Amounts	$5,000 Employee; $5,000 Spouse; $2,500 Child(ren) (50% reduction at age 70)		
Covered Conditions (lump sum payments)		**First Occurrence**	**Second Occurrence**
	Cancer		
	Invasive Cancer	100%	50%
	Carcinoma In Situ	30%	0%
	Benign Brain Tumor	75%	0%
	Skin Cancer	$250 per lifetime	Not included
	Vascular		
	Heart Attack	100%	50%
	Stroke	100%	50%
	Heart Failure	100%	50%
	Arteriosclerosis	30%	0%
	Other		
	Organ Failure	100%	50%
	Kidney Failure	100%	50%
Cancer Vaccine	$50 per lifetime for receiving a Cancer Vaccine		
Pre-Existing Condition Limitation	3 month look back period, 12 month exclusion period		

Hospital Indemnity	
Hospital Admission	$1000 per admission to a max of 1 admission per year per insured Covers hospitalization due to sickness only
Hospital Confinement	$100 per day to a max of 15 days per year, per insured
Pre-Existing Condition Limitation	3 month look back period,12 month exclusion period .

	Monthly Premium	Semi-Monthly Premium
Employee	$29.40	$14.70
Emp + Spouse	$58.30	$29.15
Emp + Children	$44.16	$22.08
Family	$73.75	$36.88

Plan Highlights:

- Portability allows the employee to take the coverage with them even if employment has ended.
- Employees over the age of 69 are not eligible to enroll in the Supplemental Health Package. After initial enrollment, Supplemental Health coverage will continue as long as an insured is actively at work.

GUARDIAN

This is a brief description of coverage. Read your certificate carefully for exact terms and conditions.

Flex Spending Accounts

Eligibility: Employees working 30 hours per week are eligible for the Flexible Spending Account the first of the month following date of hire.

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.

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 Annual Contribution: $3,300 (pre-tax)

CARRY OVER:

Up to $660 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. **Any balance over $660 will be forfeited.** You must be enrolled in a Flex Spending Account for money carried over to become part of the current plan years money. If you aren't the carry over money is only good for the previous plan year expenses and remaining balance is forfeited after December 14th.

RUN-OUT PERIOD:

A run-out period is a pre-determined time frame *after* the plan year ends. During the run-out period, you may file both health FSA and dependent care FSA claims for expenses incurred during the plan year.

Your plan year is October 1st through September 30th; the run-out period is 75 days. Beginning October 1st through December 14th you can submit claims for reimbursement, that were incurred during the previous plan year. You can not pay the expenses yourself with your FSA debit card out of the carry over money. Claims on previous year made after December 14th will be denied per IRS guidelines. IRS rules state that when the run-out period is over, you forfeit any unused funds.

10/01/25—09/30/26 FSA Plan Year	10/01/26—12/14/26 Run Out Period (Reimbursements for claims that occurred during the plan year)

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

Flex Spending Accounts

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.

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 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

Over the Counter Medications: Written prescriptions are no longer required for Over the Counter (OTC) drugs, including items like Tylenol, Claritin, Tamiflu, etc. when purchased with an FSA or HSA.

Menstrual Care Products: Menstrual care products, including items like tampons, pads, cup, etc. are now eligible expenses under an FSA or HSA.

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 and the minimum is $300 per plan year; deductions are pre-tax.** There is no rollover on Dependent Care Account funds. It is the employee's responsibility to monitor their account.

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, nursery school or Pre-K 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.

To use your Dependent Care Account for employee additional Kids Klub, employee daycare, and/or employee pre-school go to https://rosehillschools.revtrak.net/employee-flex-payments#/list to set up web store account and make payments.

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!

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! Contact Human Resources for more information and/or for help completing the Reoccurring Reimbursement Form.

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.

Are You a Gun Owner, See Gun Owner Supplement in QR Code

Have You Ever

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ 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	$16.95
IDShield	$18.95	$8.95
Combined	$33.90	$25.90

Prepared for: Rose Hill USd 394 Legal & ID Shield Overview player.vimeo.com/video/402593265 (2:41 minutes)

For more information, contact your Independent Associate:

Bob Pilcher
rpilcher.wearelegalshield.com
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.

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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

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)

NFA Gun Trust Services

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

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.

$12.95 when purchased with the Legal plan.
Covers Employee & Spouse/Partner

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

**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.

See a plan contract for specific state of residence availability and for complete terms, coverage, amounts, conditions and exclusions. This supplement is not available in all states; please check your state or province for availability. Supplement does not include assistance in making, posting, or obtaining bond, bail, or other security required for release.

Marketed by: Pre-Paid Legal Services, Inc. dba LegalShield® and subsidiaries; Pre-Paid Legal Casualty, Inc.; Pre-Paid Legal Access, Inc.; In FL: LS, Inc.; In VA: Legal Service Plans of Virginia; and PPL Legal Care of Canada Corporation.

SHEET_GunOwnerLegalPlan_031318

Retirement Plans

Will you have enough money when you want to retire? Will just your KPERS be enough?

It is important to start saving now.

Annuity/Savings Plans

All employees, including substitutes, are eligible to participate in the district 403 (b) or 457 savings program. All money placed into this plan is pre-tax. Employees wishing to participate in this option must select an annuity company from an established list of providers. A listing of companies and their contact representatives is shown at the end of this section. To be eligible for payroll deduction, the savings program must be established with a district-qualified company. A 403(b) may be established with any district-qualified company. A 457 plan is very similar to a 403(b) plan but it has different provisions concerning withdrawals and loan provisions. A 457 savings plan may only be established with the approved district 457 plan provider. To find out more about 403(b) or 457 plan investments, confer with the provider representative of your plan.

403(b) Roth

403(b) Roth contributions are not tax-deductible. But those contributions and your investment earnings grow tax-free, meaning there's no tax on your 403(b) Roth withdrawals in retirement. 403(b) Roths are a great retirement-savings account if you expect your tax rate to be higher in the future. That's because you pay income tax on your money before contributing it to the 403(b) Roth, so if your tax rate is lower now, it makes sense to pay taxes now in return for tax-free growth on your investment earnings.

You will be able to visit with company representatives regarding enrollment in or changes to a 403(b), 403(b) Roth, or 457 savings plan at any time, however all forms for enrollment, or changes made to a savings plan must be submitted to Human Resources or Payroll on forms provided by the district's third party administrator. Those forms are available from Human Resources or Payroll.

BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Retirement Plans

WHEN CAN I ENROLL?

You are eligible to enroll, at any time, immediately upon your date of hire. You may choose your plan provider from the list on the next page. Once you make your choice, you must contact the plan provider and complete the appropriate application and any other necessary forms, including a Salary Reduction Agreement. This contribution will continue unless it is modified or revoked in the future. Return all completed forms to the plan provider, Human Resources or Payroll.

CAN I CHANGE OR STOP MY ELECTIVE DEFERRAL CONTRIBUTIONS?

You may change or stop your elective deferral contributions at any time. At any time you may also change of the amount of contribution, investment direction, and/or designated beneficiary. You are permitted to revoke your election at any time during the plan year. Please contact Human Resources or Payroll for further questions or instructions.

All personnel are responsible for informing their annuity companies and the Human Resources Department or Payroll at USD 394 of changes in their annuity plans. USD 394 will only notify the third party administrator for the district of such changes.

WHEN IS MY ELECTIVE DEFERRAL CONTRIBUTION(S) EFFECTIVE?

Unless the election specifies a later effective date, a change of the amount of the elective deferral contribution(s) and/or a change in the investment direction shall take effect as of the first pay period or payment date that is at least 15 days after the date on which the Salary Reduction Agreement is received by Human Resources or Payroll. A change in the beneficiary designation shall take effect immediately when the election is turned in.

WHAT IS THE MAXIMUM AMOUNT THAT I CAN CONTRIBUTE?

The Internal Revenue Code limits the annual contributions you can make to a 403(b), 403(b) Roth and/or 457 plan and the limits are adjusted each year. The 2025 limits are as follows:

- Elective deferral limit $23,500.00
- Age 50 catch-up $ 7,500.00

Speak to a provider to find out what your best option(s) are.

WILL MY EMPLOYER MAKE ADDITIONAL CONTRIBUTIONS?

USD 394 does offer an employee match plan. The employee match plan is not available for substitutes. To be eligible for this plan, an employee must have been employed by USD 394 as of September 1, and have been continuously employed through August of the following year. Those employees who work only during the school year are considered continuously employed if they return to a regularly scheduled position for the following school year. For those employees who are hired after September 1, they become eligible when they have been continuously employed for one full plan year.

USD 394 will match all payments, dollar for dollar to a maximum of $150 per month, into a 403(b) with your choice of one of our providers. 457 and 403(b) Roth plans are eligible for this match; however, the district portion will only be placed into a 403(b) plan. Entry into this plan is limited to September 1 of each plan year. The employee must minimally place $30 per month into a 403(b), 403(b) Roth or 457 to receive the district match. If at any time during the plan year, the employee drops his/her contribution below $30 per month, then participation in the employee match plan match ends for that plan year. Re-entry into the plan match is not available until the beginning of the next plan year.

Retirement Plans

District Selected 457 Plan Providers		
Provider	**Representative**	**Phone**
American Fidelity	James LaPish	James.LaPish@americanfidelity.com
Security Benefit Life	Ian Linstrom Leasha Rutschman Ginger Hamilton	316-990-8923 316-461-5063 316-670-0048

District-Qualified Roth 403(b) Providers		
Provider	**Representative**	**Phone**
Security Benefit Life	Ian Linstrom Leasha Rutschman Ginger Hamilton	316-990-8923 316-461-5063 316-670-0049

District-Qualified Annuity 403(b) Providers		
Provider	**Representative**	**Phone**
Ameriprise Financial	Chad Langhofer Rachel Wright Dustin Stull Jonathan Earl	316-440-5353 316-440-5353 785-345-4195 620-728-2639
American Fidelity	James LaPish	James.LaPish@americanfidelity.com
Security Benefit Life	Ian Linstrom Leasha Rutschman Ginger Hamilton	316-990-8923 316-461-5063 316-670-0049

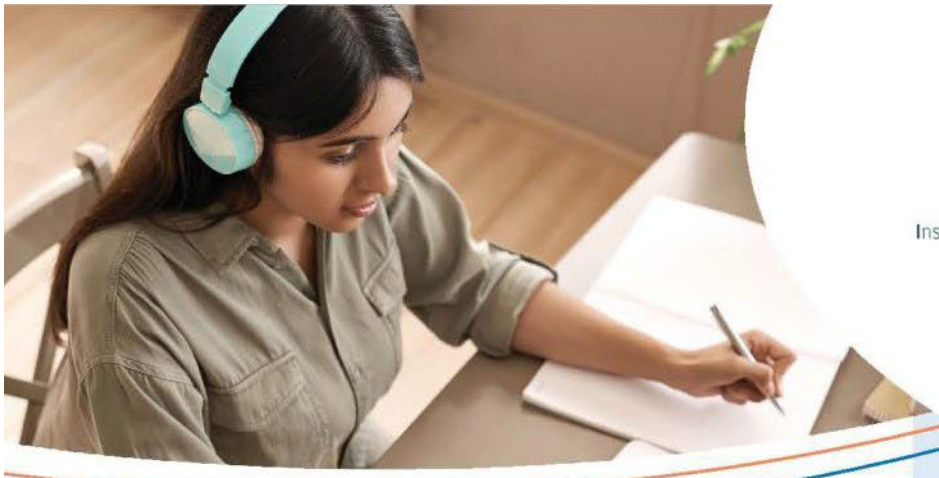
FOR ADDITIONAL INFORMATION

To learn more about 403(b) plans, please visit http://www.irs.gov and search for Publication 571. If you would like to compare a 403(b) plan and a 457 plan go to http://www.irs.gov and search for Publication 4484. If you have further questions about how the plans work, or your rights and obligations under the plan, please contact Lucy Brown.

Lucy Brown
USD 394 Human Resources
104 N Rose Hill Road
Rose Hill, Kansas 67133-9785
316-776-3300
hr@usd394.com

USD 394 Payroll
104 N Rose Hill Road
Rose Hill, Kansas 67133-9785
316-776-3300
payroll@usd394.com

Benefit Advocate Center (BAC)



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Connect with Us

USD 394 Rose Hill

Phone:
(833) 295-5143

Email:
BAC.UnifiedSchoolDistrictNo394Advocates@ajg.com

Hours of operation

Monday – Friday

8 a.m. – 6 p.m. Central Time

ajg.com The Gallagher Way. Since 1927.

Notices

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 - OPEN $2,500 Plan (Individual: 50% coinsurance and $2,500 deductible; Family: 50% coinsurance and $5,000 deductible)

Plan 2: Option 3 - OPEN $5,000 Plan (Individual: 20% coinsurance and $5,000 deductible; Family: 20% coinsurance and $10,000 deductible)

Plan 3: Option 4 - WESLEY PREFERRED $5,000 Plan (Individual: 20% coinsurance and $5,000 deductible; Family: 20% coinsurance and $10,000 deductible)

Plan 4: Option 5 - WESLEY PREFERRED $6,500 Plan (Individual: 50% coinsurance and $6,500 deductible; Family: 50% coinsurance and $13,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 316-776-3303 or hr@usd394.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

Notice of CHIPRA Policy

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 March 17, 2025. 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
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

Notices

Notice of CHIPRA Policy

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

Notice of CHIPRA Policy

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
USD 394 Rose Hill is committed to the privacy of your health information. The administrators of the USD 394 Rose Hill 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 Lucy Brown - HR Manager at 316-776-3303 or hr@usd394.com.

HIPAA Special Enrollment Rights

USD 394 Rose Hill Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the USD 394 Rose Hill 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 Lucy Brown - HR Manager at 316-776-3303 or hr@usd394.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.

Notices

Notice of Creditable Coverage

Important Notice from USD 394 Rose Hill

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 394 Rose Hill 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 394 Rose Hill 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 394 Rose Hill coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current USD 394 Rose Hill 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 394 Rose Hill 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 394 Rose Hill 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.

Notices

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: October 01, 2025
Name of Entity/Sender: USD 394 Rose Hill
Contact—Position/Office: Lucy Brown - HR Manager
Office Address: 104 N Rose Hill Rd
Rose Hill, Kansas 67133-9785
United States
Phone Number: 316-776-3303

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 plan 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

Carrier Contacts

Aetna

Member Services: 1-800-445-5299 (Se habla espanol)

Website: www.aetna.com

Download the 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 Vision

Member Services: 1-866-818-8805

Website: www.surency.com/Members/SurencyVision/

Download the Surency Vision Mobile App!

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

For questions about your claim, contact: EyeMed Vision Care at 1-866-939-3633

Surency FLEX
FSA & Limited Purpose FSA

Member Services: 1-866-818-8805

Website: www.myflexaccount.com

Email: flex@surency.com

Download the Surency Mobile App!

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

Guardian

Customer Service: 888-482-7342

Website: www.guardianlife.com

Bay Bridge Administrators, LLC.

Customer Service: 1-800-953-6260

Fax: 1-800-961-6240

Website: http://bbadmin.com/retirement/

LegalShield

Contact: Bob Pilcher 316-215-5100

Website: www.bobpilcher.com

Email: Bobpilcher58@gmail.com

Benefit Advocate

Gallagher Benefit Services

Benefit Advocate Center (BAC)

Phone: 833.295.5143

Email: BAC.UnifiedSchoolDistrictNo394Advocates@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