A Guide to Your Employee Benefits

August 1, 2024 - July 31, 2025

2024-2025 Employee Benefits

If you have questions regarding...	Contact	Call	Click
Medical Insurance	EMI Health	(800) 662-5851	www.emihealth.com
Telemedicine	EMI Health/Recuro	(855) 673-2876	www.emihealth.com
Dental Insurance	EMI Health	(800) 662-5851	www.emihealth.com
Vision Insurance	EMI Health/VSP	(800) 662-5851	www.emihealth.com
Health Savings Account	Health Equity	(866) 346-5800	www.healthequity.com
Flexible Spending Account	National Benefits Services	(800) 274-0503	www.nbsbenefits.com
Life & AD&D Insurance	Lincoln Financial	(800) 423-2765	www.lfg.com
Short-Term/Long-Term Disability	Lincoln Financial	(800) 423-2765 Customer Service	www.lfg.com
Voluntary Benefits	Voya	(877) 236-7564	https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict
Employee Assistance Program (EAP)	Lincoln Financial	(888) 628-4824	www.guidanceresources.com
Tava		https://care.tava.com	https://care.tavahealth.com/signup
Retirement Planning	Utah Retirement Systems (URS)	(800) 950-4877 (435) 673-6300	www.urs.org
Insurance Advisors	Group Benefits Services (GBS)	(435) 879-7889 Emilyann Peinamalie	Emilyann.peinamalie@gbsbenefits.com
COBRA Advisors	GBS Benefits Compliance Services	(801) 842-0148 Lorie Brown	lorie.brown@gbsbenefits.com
WCSD Human Resources & Payroll		(435) 673-3553 Phone (435) 673-3216 Fax	www.washk12.org
Benefit Coordinator		Tammara Robinson x5119	tammara.robinson@washk12.org
Benefit & Accounting		Marci Ware x5105	marci.ware@washk12.org
Wellness		Mitzi Lytle X5120	wcsd_wellness@washk12.org
Attendance & Medical Leave		Amanda Amaya x5116	amanda.amaya@washk12.org
Risk Management Specialist		Michael Lee x5110	michael.lee@washk12.org
Payroll		Tennille Mills certified x 5102 Misti Boulard classified x5118 Crystal Gorley classified x5120	tennille.mills@washk12.org Misti.boulard@washk12.org crystal.gorley@washk12.org

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Important Information

Washington County School District

Washington County School District Benefits and You

Welcome

We are committed to providing our employees with quality benefit programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset. Eligible employees have many benefit plans to choose from, so we ask that you read this benefits guide carefully to help you make the benefit elections that are the best fit for you and your family.

Know Your Benefits

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is "shop" for benefits carefully, using the same type of decision-making process you use for other major purchases.

› Take Advantage Of The Tools Available

That includes this guide, access to plan information, provider directories, and enrollment materials.

› Be a Smart Shopper

If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits.

› Don't Miss the Deadline and Keep Record of Your Enrollment

Pay attention to the enrollment deadline and be sure to provide us with your benefit elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify us immediately if there are any discrepancies. **Remember:** Once the enrollment period has ended, you may not make or change your benefit elections, unless you experience a qualified life event.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC annually during open enrollment.

For the most up-to-date information regarding the ACA, please visit www.healthcare.gov.

The District fringe benefit package is an important part of your whole compensation. The District is pleased to offer you the opportunity to select from a variety of benefit options. Eligible employees can elect participation in any or all of the following:

- Medical Insurance
  Choose one of two plan options
- Health Savings Account
- Flexible Spending Account
- Dental Insurance
- Basic Group Term Life Insurance
- Optional AD&D life Insurance & Vol Optional Life
- Short Term Disability
- Long Term Disability
- Voluntary Vision Insurance
- Voluntary Insurance (Voya)

This guide is designed to help you make decisions about what coverage is best for you and your family. Enclosed, you will find a brief description of the options available, a comparison of basic plan coverage and cost information.

This is a summary only. For more information about any of the plans, don't hesitate to contact the insurance companies directly. Provider listings can be found on the district web-site at www.washk12.org. Go to "Employees" click on "Human Resources", then click on "Benefits & Insurance", and then "Handbook". You will see vendor carrier information and carrier web addresses. Also, insurance carrier's phone numbers and web-site addresses are listed on the back cover of this guide.

Keep in mind, learning module is available to access the carrier websites. Please go to https://courses.gbsbenefits.com/WCSD-OpenEnrollment-2024
Remember, this guide is a summary only. It is not meant to replace or fully interpret provisions of the negotiated agreements, FMLA, COBRA, Washington County School District Policy, or the insurance benefits.

Please take the time to carefully go through this guide and any other information required to make decisions about benefits offered by the district. Employees, who make informed decisions about their benefit options, will have fewer questions and better access to benefits throughout the year.

Open Enrollment (OE):

Open Enrollment begins ***April 15, 2024 - April 26, 2024.*** Open Enrollment is the period of time when you, as an eligible employee, are able to enroll in insurance coverage or elect changes to your Medical, Dental, Optional Life Insurance, Vision, Short Term Disability, and Flex Spending. It is important to note that this is the only period of time that you can make changes to your benefit coverage (with the exception of changes necessary due to a change in family status or insurance eligibility status).

After you have reviewed all of this information carefully, if you decide to make a change to your insurance coverage for the 2024-2025 school years, you will need to complete the appropriate paper form by Friday, April 26, 2024.

Timeline & Events for Open Enrollment

- **Monday, April 15, 2024 - Open Enrollment Begins**
- **Friday, April 26, 2024- Open Enrollment Ends**
- **Monday, August 1, 2024 - Changes made during open enrollment become effective.**

Tammara Robinson
(435) 673-3553 ext. 5119
tammara.robinson@washk12.org

Marci Ware
(435) 673-3555 ext. 5105
marci.ware@washk12.org

New Hire Enrollment:

If you are a newly hired or newly eligible employee, you will be *automatically enrolled in the "Qualified High Deductible Health Plan" medical plan as employee with SINGLE coverage effective the 1st of the month following your eligible contract. If you choose to change to the "traditional" health plan, add dental and all other supplemental insurance plans, or add your family, you are required to enroll within 30 days of hire or eligibility date. It is imperative that you complete the new hire orientation and benefits meeting in order to learn about the insurance benefits. if enrollment is not completed timely, this could result in benefits being delayed until the following month

REMINDER, AUTOMATIC ENROLLMENT IS MEDICAL SINGLE COVERAGE ON THE HIGH DEDUCTIBLE HEALTH PLAN. ATTEND NEW HIRE ORIENTATION FOR ADDITIONAL BENEFIT OPTIONS AND TO ADD FAMILY MEMBERS

Who is Eligible?

If you are hired as a full-time employee working 30 or more hours per week, coverage will begin on the first day of the month following 30 days of qualified employment. You may also enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered.

How We Define Medical Benefits Eligibility

We are a large employer according to the Employer Shared Responsibility provisions of the ACA. The enrollment guidelines listed in this guide may vary if you are hired to work less than 30 hours per week (130 hours per month) or your hours worked drop below the threshold. Please contact us for our complete policy on Measurement Methods to determine full-time benefits eligibility status under the Employer Shared Responsibility.

When to Enroll

You can enroll for coverage as a new hire, or during our annual open enrollment period. Outside of the annual open enrollment period, the only time you can change your coverage is if you experience a qualifying life event. Employees who decline coverage, or fail to enroll for coverage, at their initial eligibility shall be subject to insurance benefit restrictions as outlined in the insurance contracts.

How to Make Changes

Once you enroll in or decline benefits, you will not be able to make any changes to your elections until our next annual open enrollment period, unless you experience a qualified life event. Qualified life events include, but are not limited to:

- Change in your legal marital status
- Birth, adoption, placement for adoption or legal guardianship of a child
- Death of a dependent
- Change in child's dependent status
- You or your dependent(s) become eligible or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Change in your dependent's employment resulting in loss or gain of eligibility for employer coverage
- A court or administrative order

If your qualified life event is due to loss or gain of Medicaid or CHIP coverage, you have **60 days** to complete the necessary enrollment forms and return them to us. All other qualified life events must be reported to us within **30 days** of the event. It is your responsibility to notify us when you have a qualified life event and would like to make changes to your benefit elections. Please do not miss this important deadline!

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which your regular work schedule is reduced to fewer than 30 hours per week, your employment ends, or you stop paying your share of the coverage. Your dependent(s) coverage ends when your coverage ends, or the last day of the month in which the dependent is no longer eligible. Certain benefits may terminate on the date of event.

Section 125 Flexible Spending Benefit Plan Enrollment:

For participation in the Section 125 Flexible Benefit Plan from August 1, 2024 through July 31, 2025, you **must complete** enrollment via Paper Application. To learn more about the National Benefit Services Cafeteria Plan, review the appropriate section in this booklet. **The deadline for the flexible spending enrollment is Friday, April 26, 2024.**

Limited-Purpose FSA: This type of FSA can be used in conjunction with a health savings account (HSA). A limited-purpose FSA (LPFSA) allows you to contribute pre-tax dollars to use for dental and/or vision expenses only. This allows you to maximize your pre-tax HSA contributions and contribute additional pre-tax dollars to an LPFSA.

IMPORTANT NOTE: If you enroll in the Qualified High Deductible Health Plan (QHDHP) and Health Savings Account (HSA), you are not eligible to enroll in the Flex Plan for health/medical expenses. This does not affect the Flex Plan for Dependent Child Care.

Medical

EMI - Care Plus Network
$1,500 Traditional Plan
Option 1

All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.

Washington County School District August 01, 2024 - July 31, 2025 Option 1	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	$5,000 / $10,000	$10,000 / $20,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). Please note ♦	$1,500 / $3,000	$3,000 / $6,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)	**YOU PAY**	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note ●	$100	
Participating Pharmacy (up to 30 day supply)	Generic - $10 ●Preferred - $25 ●Non-Preferred - $45	
Non-Participating Pharmacy	Not Covered	
Mail Order (up to 90 day supply)	Generic - $10 ●Preferred - $50 ●Non-Preferred - $135	
Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	●$100	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *$0 Copay	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Hearing Exam (1 visit per Year)	Covered 100%	Not Covered
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	$30	♦40%
Physician Office Visits (secondary care)	$60	♦40%
Physician Office Visits (after hours)	$60	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Surgery (Ambulatory Surgical Center)	♦5%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Anesthesiology (Ambulatory Surgical Center)	♦5%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	$60	♦40%
Neurodevelopmental Therapy (Outpatient physical, speech and occupational – Ages birth thru 6, limited to 40 visits per Year)	$60	♦40%
Chiropractic Therapy (15 visits per Year)	$60	♦40%
Allergy Testing	20%	♦40%

Washington County School District August 01, 2024 - July 31, 2025 Option 1	Care Plus Participating Provider Option	 Non-Participating Provider Option
Allergy Treatment/Serum	20%	♦40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Medical/Surgical Care (Ambulatory Surgical Center)	♦5%	♦40%
Emergency Room (ER)	$325	$325
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	♦40%
Minor Diagnostic Test, X-ray, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Newborn	20%	40%
InstaCare/Urgent Care Clinic	$60	♦40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦20%	♦40%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit to the Maximum Allowable Charge
Ambulance Land/Air (Accident & Life-threatening)	♦20%	
Orthodontic Injury Treatment	♦50%	
Dental Injury Treatment	♦20%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	$50	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	Covered 100%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$30	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment (Limited to $2000 per person per lifetime)	♦20%	♦40%
Orthognathic/Mandibular Osteotomy	♦20%	♦40%
Total Parenteral Nutrition (TPN)	♦20%	♦40%
Initial assessment and diagnosis of Primary Infertility (Limited to $5000 per Year)	♦50%	Not Covered
Reduction Mammoplasty	♦20%	♦40%
Autism Applied Behavior Analysis	♦20%	♦40%
Nutritional Counseling (Limited to 3 visits per person per lifetime)	♦20%	♦40%

Services designated ● are subject to the Prescription Drug Deductible.

Services designated ♦ are subject to the Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Outside of Utah	Cigna PPO

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

Medical

EMI - Care Plus Network
HSA - $2,000 High Deductible Health Plan
Option 2

Administered by Educators Mutual Insurance Association
EMI Health Customer Service 801-262-7475 or 1-800-662-5851
Self Funded Employee Medical Benefit Plan

All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.

Washington County School District August 01, 2024 - July 31, 2025 Option 2 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Employee Only Coverage		
Out-of-Pocket Maximum (Per Year)	$5,000	$6,500
Medical Deductible (Per Year). Please note ♦	$2,000	$2,250
Two Party and Family Coverage		
Out-of-Pocket Maximum (Per Person/Family Per Year)	$5,000 / $10,000	$6,500 / $13,000
Medical Deductible (Per Year). Please note ♦	$4,000	$4,500
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)	**YOU PAY**	
Participating Pharmacy (up to 30 day supply) Deductible waived for medications on the Exclusive Maintenance Drug list found at http://emihealth.com/pdf/Exclusive.pdf	♦Generic - $7 ♦Preferred - $21 ♦Non-Preferred - $42	
Non-Participating Pharmacy	Not Covered	
Mail Order (up to 90 day supply) Deductible waived for medications on the Exclusive Maintenance Drug list found at http://emihealth.com/pdf/Exclusive.pdf	♦Generic - $7 ♦Preferred - $42 ♦Non-Preferred - $126	
Specialty Pharmacy (up to 90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	♦$100	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *$0 Copay	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Hearing Exam (1 visit per Year)	Covered 100%	Not Covered
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	♦20%	♦40%
Physician Office Visits (secondary care)	♦20%	♦40%
Physician Office Visits (after hours)	♦20%	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Injections (office)	♦20%	♦40%
Surgery (office)	♦20%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Surgery (Ambulatory Surgical Center)	♦5%	♦40%
Anesthesiology (office)	♦20%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Anesthesiology (Ambulatory Surgical Center)	♦5%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	♦20%	♦40%
Neurodevelopmental Therapy (Outpatient physical, speech and occupational – Ages birth thru 6, limited to 40 visits per Year)	♦20%	♦40%
Chiropractic Therapy (15 visits per Year)	♦20%	♦40%
Allergy Testing	♦20%	♦40%

Washington County School District August 01, 2024 - July 31, 2025 Option 2 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	♦20%	♦40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Medical/Surgical Care (Ambulatory Surgical Center)	♦5%	♦40%
Emergency Room (ER)	♦20%	♦20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Newborn	♦20%	♦40%
InstaCare/Urgent Care Clinic	♦20%	♦40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦20%	♦40%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit to the Maximum Allowable Charge
Ambulance Land/Air (Accident & Life-threatening)	♦20%	
Orthodontic Injury Treatment	♦20%	
Dental Injury Treatment	♦20%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	♦$42	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	♦20%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦20%	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment (Limited to $2000 per person per lifetime)	♦20%	♦40%
Orthognathic/Mandibular Osteotomy	♦20%	♦40%
Total Parenteral Nutrition (TPN)	♦20%	♦40%
Initial assessment and diagnosis of Primary Infertility (Limited to $5000 per Year)	♦50%	Not Covered
Reduction Mammoplasty	♦20%	♦40%
Autism Applied Behavior Analysis	♦20%	♦40%
Nutritional Counseling (Limited to 3 visits per person per lifetime)	♦20%	♦40%

Services designated ♦ are subject to the Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Outside of Utah	Cigna PPO

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

This represents a list of maintenance medications that are covered prior to having met the medical deductible for those enrolled in the Washington County School District High Deductible Health Plan (HDHP).

Exclusive Maintenance Drug List

ANTICONVULSANTS
Carbamazepine tablets, chewable tablets
Carbamazepine suspension
Divalproex capsules
Divalproex DR tablets
Divalproex ER tablets
Ethosuximide capsules, solution
Gabapentin capsules, tablets
Lamotrigine IR tablets, chewable tablets
Levetiracetam tablets, solution
Levetiracetam ER tablets
Lithium carbonate capsules, tablets
Lithium carbonate ER tablets
Oxcarbazepine tablets
Phenytoin sodium extended capsules
Primidone tablets
Topiramate tablets
Valproate sodium solution
Zonisamide capsules

CARDIOVASCULAR

Anticoagulants/ Antiplatelets
Cilostazol tablets
Clopidogrel tablets
Dipyridamole tablets
Prasugrel tablets
Warfarin tablets

Beta Blockers
Acebutolol capsules
Atenolol
Betaxolol tablets
Bisoprolol fumarate tablets
Carvedilol tablets
Labetalol tablets
Metoprolol succinate ER tablets
Metoprolol tartrate tablets (except 37.5mg and 75mg)
Propranolol tablets
Sotalol tablets
Sotatol AF tablets

Calcium Channel Blockers
Amlodipine tablets
Diltiazem ER capsules, tablets
Diltiazem IR capsules, tablets
Diltiazem SR capsules, tablets
Felodipine ER tablets
Isradipine capsules
Nifedipine capsules
Nifedipine ER tablets (osmotic release)

Cholesterol
Atorvastatin tablets
Lovastatin tablets
Pravastatin tablets
Rosuvastatin tablets
Simvastatin tablets

Combination products
Amiloride-HCTZ tablets
Amlodipine-benazepril capsules
Amlodipine-olmesartan medoxomil tablets
Amlodipine-valsartan tablets
Atenolol-chlorthalidone tablets
Benazepril-EICTZ tablets
Bisoprolol-HCTZ tablets
Enalapril-HCTZ tablets
Fosinopril sodium-HCTZ tablets
Irbesartan-HCTZ tablets
Lisinopril-HCTZ tablets
Losartan-HCTZ tablets
Metoprolol-HCTZ tablets
Moexipril-HCTZ tablets
Olmesartan-HCTZ tablets
Quinapril-HCTZ tablets
Spironolactone-HCTZ tablets
Triamterene-HCTZ capsules, tablets
Telmisartan-HCTZ tablets
Valsartan-HCTZ tablets

Diuretics
Acetazolamide tablets
Amiloride tablets
Bumetanide tablets
Chlorothiazide tablets
Chlorthalidone tablets
Furosemide tablets, solution
Hydrochlorothiazide capsules, tablets
Indapamide tablets
Spironolactone tablets
Torsemide tablets

Other
Clonidine patches
Digoxin tablets

Renin/ Angiotensin System Antagonists
Venazepril tablets
Enalapril tablets
Eplerenone tablets
Fosinopril tablets

Renin/ Angiotensin System Antagonists cont.
Irbesartan tablets
lisinopril tablets
Losartan tablets
Moexipril tablets
Olmesartan tablets
Erindopril erbumine tablets
Quinapril tablets
Ramipril tablets
Telmisartan tablets
Trandolapril tablets
Valsartan tablets
Verapamil tablets
Verapamil ER tablets

Vasodilators
Losartan tablets
Moexipril tablets
Olmesartan tablets
Erindopril erbumine tablets
Quinapril tablets
Ramipril tablets
Telmisartan tablets
Trandolapril tablets
Valsartan tablets
Verapamil tablets
Verapamil ER tablets

DIABETES

Glucose Rescue Products
GlucaGen® HypoKit®
Glucagon®

Insulins
Humalog® products
Humulin® products
generic Lantus® products (Semglee y/f)
Levemir® products
Toujeo® products
Tresiba ® products

Metformin products
Glipizide-metformin tablets
Glyburide-metformin tablets
Metformin tablets
Metformin ER tablets (non-osmotic, non-modified)

Other
Pioglitazone tablets

This represents a list of maintenance medications that are covered prior to having met the medical deductible for those enrolled in the Washington County School District High Deductible Health Plan (HDHP).

Exclusive Maintenance Drug List

Sulfonylureas
Glimepiride tablets
Glipizide tablets
Glipizide ER tablets
Glyburide tablets
Glyburide micronized tablets
Tolazamide tablets

Testing Strips
LifeScan OneTouch® products

MENTAL HEALTH
Amitriptyline tablets
Aripiprazole tablets (non-ODT)
Bupropion ER/SR tablets
Bupropion IR tablets
Bupropion XL tablets
Citalopram tablets, solution
Desvenlafaxine succinate SR tablets
Doxepin capsules, solution
Duloxetine capsules (except 40mg)
Escitalopram tablets, solution
Fluoxetine capsules, solution
Fluvoxamine IR tablets
Haloperidol tablets, oral concentrate
Loxapine succinate capsules
Mirtazapine tablets (non-ODT)
Nortriptyline capsules, solution
Olanzapine tablets (non-ODT)
Paroxetine tablets
Quetiapine IR tablets
Quetiapine SR tablets
Risperidone tablets (non-ODT
Sertraline tablets, solution
Thioridazine tablets
Venlafaxine ER capsules
Venlafaxine IR tablets
Ziprasidone capsules

OSTEOPOROSIS
Alendronate tablets (except 40mg)
Ibandronate tablets

RESPIRATORY

Anticho Iinergics
Ipratropium bromide solution

Inhaled Corticosteroids
Budesonide (inhalation) nebulized
QVAR® inhaler
QVAR® RediHaler™

Leukotriene Receptor Antagonists
Montelukast chewable tablets
Montelukast tablets

Methylxanthines
Theophylline elixir
Theophylline CR tablets
Theophylline solutionTheophylline ER tablets, 72 hour and 24 hour

Short Acting Beta Agonists (SABA)
Albuterol nebulized
Albuterol syrup
ProAir® HFA inhaler
ProAir® RespiClick®
Ventolin® HFA inhaler

SABA/ Anticholinergics
Ipratropium-albuterol inhaler
Ipratropium-albuterol nebulized

EMI HEALTH

2024 SaveOnSp Program

In partnership with Express Scripts, Accredo Specialty Pharmacy and SaveOnSP, LLC

Pay $0 for Select Specialty Medications

- Specialty medications can cost a lot of money. That's why your plan offers a program called SaveOnSP, which can help lower your out-of-pocket costs to $0. And there's no extra cost to participate.
  - No accumulations will be applied to the deductible or Out-of-Pocket Maximum.
  - Outside of the program, the normal benefit is often a 25% coinsurance.
- Enrolled clients are seeing plan savings of over $1,300 per month per script
- Available for High Deductible and Traditional Plans.
- Specialty Drug spending as a percentage of overall Prescription drug costs have increased from 15% to over 45% in the past 10 years. The SaveOnSP program is a way to reduce costs for the member and plan.

Start Saving Today!

It's quick and easy. Call 1-800-683-1074 and speak with SaveOnSP.

Once you've completed the manufacturer copay assistance program's enrollment process and consented to SaveOnSP monitoring your pharmacy account, your responsibility will be reduced.

Enrollment in the SaveonSP program is voluntary; however, if you elect not to participate, you will be responsible for 100% of the SaveonSP Specialty copay. This copayment amount will not apply toward your out-of-pocket maximums. Participation may not disqualify an individual from being an eligible individual for HSA purposes. Material contained in this document does not constitute legal or tax advice and should not be construed as such. If you need legal advice upon which you can rely, you must seek a legal opinion from a competent attorney.

The SaveOnSP Drug List is subject to change at any time. The inclusion of a particular specialty prescription drugs within the SaveOnSP Program is subject to SaveOnSP Program design, as well as applicable laws or regulations. Prescription benefit plan terms will take precedence and determine access to all specialty prescription drugs on SaveOnSP Drug List; medical benefit drugs are excluded from the SaveOnSP Program.

EMI.MKTG.SAVEONSP.1123.1418

EMI HEALTH

Copay Assistance Benefit Drug List

Effective January 1, 2024

The specialty medications included in the copay assistance benefit drug list are specific to your plan's prescription drug benefit and subject to change at any time.

A

Abraxane
Abrilada
Actemra
Adakveo
Adalimumab-adaz
Adbry
Adcetris
Adcirca
Adempas
Advate
Adynovate
Afinitor
Afstyla
Aldurazyme
Alecensa
AlphaNine
Alprolix
Altuviiio
Alunbrig
Amjevita
Ampyra
Amvuttra
Arcalyst
Asceniv
Austedo
Avastin
Avonex
Avsola
Ayvakit

B

Bafiertam
Balversa
Bavencio
Benefix
Benlysta Beovu
Berinert
Betaseron
Bivigam
Bosulif
Braftovi
Briumvi
Brukinsa

C

Cablivi
Cabometyx
Calquence
Camzyos
Caprelsa
Carbaglu
Cayston
Cerdelga
Cerezyme
Cholbam
Cibinqo
Cimerli
Cimzia
Cinryze
Columvi
Cometriq
Copaxone
Copiktra
Cortrophin
Cosentyx
Cotellic
Crysvita
Cutaquig
Cuvitru
Cyltezo
Cyramza
Cystadrops

D

Daurismo
Daybue
Dojolvi
Doptelet
Dupixent
Durysta

E

Elahere
Elaprase
Elelyso
Elfabrio
Eloctate
Empaveli
Empliciti
Enbrel
Enhertu
Enjaymo
Enspryng
Entyvio
Epclusa
Epkinly
Erbitux
Erivedge
Erleada
Esbriet
Esperoct
Evenity
Evkeeza
Exjade
Exkivity
Exondys 51
Extavia
Eylea

F

Fabrazyme
Fasenra
Feiba NF
Ferriprox
Filspari
Fintepla
Firazyr
Firdapse
Folotyn
Forteo
Fotivda
Fulphila
Fyarro
Fylnetra

G

Galafold
Gamifant
Gammagard
Gattex
Gavreto
Gazyva
Gilotrif
Givlaari
Glatiramer Acetate
Glatopa
Gleevec
Gocovri
Granix

H

Haegarda
Halaven
Harvoni
Hemlibra
Herceptin
Herceptin Hylecta
Herzuma
Hetlioz
Humate-P
Humira
Hyqvia
Hyrimoz

I

Ibrance
Iclusig
Idelvion
IDHIFA
Ilaris
Ilumya
Imbruvica
Imcivree
Imfinzi
Increlex
Inflectra
Ingrezza
Inlyta
Inqovi
Inrebic
Iressa
Ixempra
Ixinity

J

Jadenu
Jakafi
Jaypirca
Jemperli
Jevtana
Jivi
Joenja
Juxtapid
Jynarque

K

Kadcyla
Kalbitor
Kalydeco
Kanjinti
Kanuma
Kesimpta
Keveyis
Kevzara
Kineret
Kisqali
Kisqali Femara Co-Pack
Kitabis
Kogenate FS
Koselugo
Kovaltry
Krazati
Krystexxa
Kuvan
Kyprolis

L

Lamzede
Ledipasvir/Sofosbuvir
Lemtrada
Lenvima
Leqembi
Letairis
Leukine
Libtayo
Livmarli
Lonsurf
Lorbrena
Lucentis
Lumakras
Lumizyme
Lumryz

EMI HEALTH

Lunsumio
Lupkynis
Luxturna
Lynparza

M

Margenza
Mayzent
Mekinist
Mektovi
Mvasi
Myalept

N

Nerlynx
Neulasta
Neupogen
Nexavar
Nexviazyme
Ninlaro
Nityr
Nivestym
Northera
Novoeight
Novoseven RT
Nplate
Nubeqa
Nucala
Nulibry
Nuplazid
Nuwiq
Nyvepria

O

Ocaliva
Ocrevus
Odomzo
Ofev
Ogivri
Olumiant
Ontruzant
Onureg
Opdivo
Opdualag
Opsumit
Orencia
Orenitram
Orfadin
Orgovyx
Orkambi
Orladeyo
Orserdu
Otezla
Oxbryta
Oxervate
Oxlumo

P

Padcev
Palynziq
Pemazyre
Perjeta
Phesgo
Piqray
Plegridy
Polivy
Ponvory
Poteligeo
Procysbi
Promacta
Pulmozyme
Pyrukynd

Q

Qalsody
Qinlock

R

Radicava
Ravicti
Rebif
Rebinyn
Recombinate
Releuko
Remicade
Renflexis
Retevmo
Revatio
Revcovi
Revlimid
Rezlidhia
Riabni
Rinvoq
Rituxan
Rituxan Hycela
Rixubis
Rolvedon
Rozlytrek
Ruxience
Rybrevant
Rydapt
Rystiggo

S

Sandostatin Lar Depot
Saphnelo
Sarclisa
Scemblix
Serostim
Sevenfact
Signifor
Signifor LAR
Siliq
Simponi
Skyclarys
Skyrizi
Skysona
Skytrofa
sodium oxybate
Sofosbuvir/Velpatasvir
Soliris
Somatuline Depot
Somavert
Sotyktu
Sovaldi
Spinraza
Sprycel
Stelara
Stivarga
Strensiq
Sublocade
Susvimo
Sutent
Syfovre
Sylvant
Symdeko
Synagis

T

Tabrecta
Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Targretin
Tasigna
Tavalisse
Tavneos
Tazverik
Tecentriq
Tecfidera
Tegsedi
Tepezza
Tepmetko
Teriparatide
Tezspire
Thiola
Tibsovo
Tivdak
Tobi
Tracleer
Truxima
Tukysa
Turalio
Tykerb
Tymlos
Tysabri
Tyvaso
Tzield

U

Udenyca
Ultomiris
Uptravi

V

Vabysmo
Valchlor
Vanflyta
Vectibix
Venclexta
Verzenio
Vijoice
Viltepso
Vistogard
Vitrakvi
Vivitrol
Vizimpro
Vonjo
Vonvendi
Vosevi
Votrient
Vowst
Voxzogo
Vpriv
Vumerity
Vyjuvek
Vyleesi
Vyndamax
Vyndaqel
Vyondys 53
Vyvgart
Vyvgart Hytrulo
Vyxeos

W

Wakix
Welireg
Wilate

X

Xalkori
Xeljanz
Xembify
Xenazine
Xenpozyme
Xermelo
Xgeva
Xolair
Xospata
Xpovio
Xtandi
Xyntha
Xyrem

Y

Yervoy
Yonsa
Yusimry

Z

Zarxio
Zejula
Zelboraf
Zeposia
Ziextenzo
Zirabev
Zokinvy
Zolgensma
Ztalmy
Zydelig
Zykadia
Zynlonta
Zynteglo
Zynyz
Zytiga

Stretching Your Rx Dollar

GoodRx Comparison Tool

Stop paying too much for your prescriptions! With the GoodRx Comparison Tool, you can compare drug prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Isn't health insurance all I need?

Your health insurance provides valuable prescription and other health benefits, but a smart consumer can save much more, especially for drugs that are not covered by health insurance (weight-loss medications, some antihistamines, etc.), drugs that have limited quantities, drugs that can be found for less than your copay, or drugs with a lower priced generic.

How can I find these savings?

The GoodRx Comparison Tool provides you with instant access to current prices on more than 6,000 drugs at virtually every pharmacy in America.

› **On the Web:** https://www.goodrx.com/

Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.

Please Note:

- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90-day supply.

› **On Your Phone**

Available on the App Store or with Android on Google play. Or, just go to m.goodrx.com from any mobile phone.

Generic Prescriptions

$4 30-Day Supply or a $10 90-Day Supply

These programs may assist you in paying a reduced amount for generic medications, as well as, reducing utilization of the medical prescription benefits.

Did You Know?

Even if the generic substitute for one of your prescription drugs is not on one of the $4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from a switch to a generic drug, do some comparison shopping. One of the better places to do this is at www.crbestbuydrugs.org, a Consumer Reports site.

Tips

- When you receive a prescription from your doctor, ask if a generic equivalent is available.
- The member must present the written prescription to the pharmacist and request the $4-Generic price.
- The member should not present the medical ID card. The pharmacy will not submit a claim to the insurance carrier.

How can I find out if my prescription is on the $4-Generic Drug List?

Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price. The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.

You may search for the generic medication on the pharmacy's website or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's $4-Generic Drug List.

TeleMedicine

$0 copay for all plans

Reach a doctor 24/7/365.

70% of doctor visits can be handled over the phone, and 40% of urgent care visits can be managed using TeleMedicine. Save time and money while still getting the treatment you need through EMI Health TeleMed offered through Recuro.

When to Use TeleMed

Recuro doctors diagnose acute, non-emergent medical conditions and prescribe medications when clinically appropriate.

Speak with a doctor anytime and pay no consultation fee rather than paying the high costs associated with office visits, urgent care visits, and emergency room visits.

Just call **855.6RECURO.**

Video consultations are available as well from 7 AM - 7 PM.

Common Conditions

- Acid Reflux
- Allergies
- Asthma
- Bladder Infection
- Bronchitis
- Cold & Flu
- Constipation
- Cough
- Ear Pain*
- Fever
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Joint Pain
- Nausea
- Pink Eye
- Rashes
- Sinus Conditions
- Sore Throat
- Stomach Virus
- Thyroid Conditions
- Urinary Tract Infections
- Yeast Infections

**In accordance with telemedicine guidelines, ear infections are only diagnosed for patients that are 18 years of age or older.*

Common Medications

- Albuterol
- Allegra
- Asthma
- Flonase
- Ibuprofen 800 mg
- Levaquin
- Lipitor
- Nasonex
- Many Others

855.6RECURO

Download the Recuro mobile app

EMI.MKTG.TELEMEDANDMH.1119.1241

lyra

EMI HEALTH™

OVERVIEW

Mental Health Made Easy

Educators Mutual Insurance Association (EMI) members have fast access to high-quality mental health care coaches and therapists in just a few clicks.

Therapy

Meet with a therapist for diagnosis and treatment of mental health conditions like depression, anxiety, substance use, and more.

Mental health coaching

Find care with a mental health coach to support you through managing stress, low confidence or self-doubt, relationship issues, and more via video.

Find care and get started

Getting started is easy

Share what you're experiencing, get care recommendations, and book an appointment immediately. With easy access to high-quality providers, Lyra members feel better faster.

High-quality care that works

Lyra is dedicated to offering the best care possible and supporting only treatments that are the most effective at relieving symptoms, typically within a short period of time.

The best coaches, therapists and physicians available nationwide

Our providers are ready to meet you where you are — via live video, live messaging, or even in-person. Many use digital lessons and exercises to enhance your care experience between sessions.

Who is eligible?

EMI members have access to Lyra Health's provider network of coaches and therapists. Sessions are billed through EMI and subject to in-network outpatient mental health cost-sharing, as defined under your health plan.

Learn more at emihealth.lyrahealth.com

(877) 299-4765 | care@lyrahealth.com

Communication to WCSD Employees and Students March 19, 2024

Family Healthcare provides medical visits for all.
Washington County School District Employees for $30.
And ALL Washington County School District Students for $10.

Family Healthcare follows a healthcare model that provides the right care, at the right time, in the most cost-efficient way. The model emphasizes preventive care provided by a high quality consistent patient-centered healthcare team which includes a board certified licensed physician, nurse practitioner or physician assistant supported by a medical assistant, behavioral health provider, nurse, care coordinator, and clerical staff.

Services include, but are not limited to:

• Family health care	• Women's health care services
• Teenage physicals	• Sick visits
• Scout physicals	• Management of acute and chronic problems
• Team physicals	• Preventative health care
• Infant and child health care	• Access to reduced cost prescriptions
• Adolescent medicine	• Adult physicals and well care

Note: Bloodwork, as well as some immunizations and procedures may result in additional fees.

Three locations in Washington County:

Hurricane Clinic	Riverside Clinic St. George	Zion Canyon Clinic Springdale
391 North 200 West, Hurricane On Hurricane Middle School Campus Medical & Behavioral: 435-986-2565 Mon 8 am – 8 pm Tues 8 am – 6:30 pm W/TH/F 8 am –5 pm **Lunch closure 12-1** Closed Sat, Sun	2276 E Riverside Drive, St George Medical/Behavioral: 435-986-2565 Dental: 435-359-2165 Pharmacy: 435-359-9899 Mon to Fri 8 am - 8 pm Sat 7 am – 1 pm Closed Sun	120 Lion Blvd. Springdale Medical: 435-986-2565 **Nov thru March** M & TH 8 am – 6 pm **April thru Oct** M/T/W/Fri 8 am – 5 pm Thurs 8 am – 6 pm **Lunch closure 12-1** Closed Sat, Sun

Pre-scheduled, Walk-in, Urgent Care, Same day, & Telehealth appointments available.
Patients seen in one location may access services offered at other locations.

Unlock exclusive benefits and savings on your medical plan!

Washington County School District employees, rejoice! We're excited to share two fantastic facilities in St. George, Utah, designed to enhance your well-being while saving you money on healthcare expenses. Take advantage of state-of-the-art facilities and services tailored to meet your needs, ensuring a healthier and more cost-effective approach to your medical care. Join us in prioritizing your health and financial well-being with these incredible resources available to you!

10:30

Scan now to learn how you can save money and the benefits to making smart healthcare consumer decisions!

Coral Desert Surgery Center

Do you have an upcoming Outpatient Surgery/Service? If you do, we have some great news for you!

Washington County School Districts medical plan with EMI Health helps you save money for using High Quality Low Cost Facilities.

If you choose to utilize the Coral Desert Surgery Center located in St. George, you can receive lower out of pocket costs. Services such as: Knee Scopes, Colonoscopies, Fracture Repairs, Hernia Repairs, Carpel Tunnel Repair, and Many Others. Please always be sure to ask your doctor and/or EMI if your specific surgery/service is eligible to be completed at the Coral Desert Surgery Center.

By utilizing the Coral Desert Surgery Center, once you have met your deductible on either the Traditional plan option or High Deductible Health plan option you will have a reduced coinsurance of 5% vs the regular 20% coinsurance at other facilities!

Not only does Coral Desert help you reduce your costs by unlocking this exclusive reduced coinsurance, they also have lower overall charges for their procedures. The total cost billed to your insurance plan is most of the time quite a bit less than what you would see at other facilities around town. This advantage will help lower your cost exposure for a procedure and will help reduce claims costs for the overall EMI plan which allows for premium cost control in the future. Healthcare premium costs are always on the rise so lets do anything we can to help positively influence those costs by making smart decisions with our healthcare needs.

Let's work together to help keep health care costs down for everyone on our plan and remember the benefits to being a smart consumer for your health care needs!

Revere Health

As you know Revere Health located in St. George is IN-Network with your EMI Health plan, we wanted to take a minute to remind you of the many services Revere Health can offer!

Things like:

- Primary Care (Adult, Family, Internal, Pediatrics)
- Urgent Care
- Orthopedics (Pain Management, Sports Med, Joint, Osteoporosis, etc)
- Cardiology
- Diagnostic and Other Services (Imaging, Laboratory, Pharmacy, Radiology)
- Specialty Medicine

Even if your Primary doctor is located at or with Intermountain Healthcare you can still request services be performed at Revere Health to help lower your healthcare costs.

Health Savings Account

HealthEquity

Health Savings Account

About Health Savings Accounts

A Health Savings Account (HSA) is a tax advantaged savings account that you own and control. HSAs are similar to retirement accounts in that funds rollover year-to-year, it is portable if you move jobs or retire, the balance can be invested in mutual funds, and there are survivor benefits.

The HSA Advantage

- It's a Tax Saver
    - Contributions are excluded from federal income tax
    - Your money grows tax-free
    - Withdrawals used to pay for qualified health care expenses are also tax-free
- Ownership: The money in your HSA is always yours. Unspent balances simply roll over from year to year until spent.
- Flexibility: You decide when and how much to contribute to your account.
- Portable: Your money stays put even if you change health plans or employers, or if you retire.

Who is eligible?

You must be enrolled in our qualified high deductible health plan (HDHP) and meet the following requirements:

- Have no other health insurance coverage except what's permitted by the IRS
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

How much can I contribute to my HSA?

Each year the IRS establishes the maximum contribution limits (see the table below). These limits are for the total funds contributed, including company contributions, your contributions and any other contributions. Please keep in mind you can change your HSA allocation at any time during the plan year.

	2024
Self-Only	$4,150
Family	$8,300

At age 55, an additional $1,000 contribution is allowed annually.

Determining Your Annual Contribution

Your allowed annual contribution is calculated based on the number of months covered by a qualified HDHP plan and your coverage type (self-only or family). For example, if you have self-only coverage 8 months of the year, your maximum contribution limit is $2,766. Formula: $2,766 = 8 x ($4,150 / 12)

Per the last-month rule (IRS Publication 969), if you are eligible on the 1st day of the last month of your tax year (usually December 1st), you are considered eligible for the entire year. You may contribute up to the annual maximum IRS limit, but only if you maintain qualified HDHP coverage for the entire following year.

Our Banking Partner

We have partnered with HealthEquity for HSA administration. For newly enrolled employees, your demographic data is transmitted to the bank upon electing our qualified HDHP. HealthEquity will mail you a welcome kit upon activating your account which will contain information about the bank and how to use the online banking features and your debit card. If you are an existing account holder, you will continue to use your same Health Savings Account which rolls over year after year. Please use the same debit card you currently have. The bank will automatically send you a new debit card approximately one month before your current card expires.

Health Savings Account

Qualified Health Care Expenses

You can use money in your HSA to pay for any qualified health care expenses you, your legal spouse and your tax dependents incur, even if they are not covered on your plan. Qualified health care expenses are designated by the IRS (Publication 502). They include medical, dental, vision and prescription expenses not covered by the insurance carrier.

Qualified expenses include, but are not limited to:

- Acupuncture
- Alcoholism (rehab)
- Ambulance
- Amounts not covered under another health plan
- Annual physical examination
- Artificial limbs
- Birth control pills/prescription contraceptives
- Body scans
- Post-mastectomy breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eyeglasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed)
- Nursing home medical care
- Nursing services
- Optometrist
- Lasik surgery
- Orthodontia
- Oxygen
- Stop-smoking programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment for the hearing-impaired
- Therapy
- Transplants
- Weight-loss program (prescribed)
- Wheelchairs
- Wigs (prescribed)
- Over-the-counter drugs without a prescription

Non-qualified expenses include any expenses incurred before you establish your HSA. Other non-qualified expenses include, but are not limited to:

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral Expenses
- Future medical care
- Hair transplants
- Health club dues
- Insurance premiums*
- Medicines and drugs from other countries
- Teeth whitening

The following insurance premiums may be reimbursed from your HSA:

- COBRA premiums
- Health insurance premiums while receiving unemployment benefits
- Qualified long-term care premiums
- Medicare premiums (Parts A, B, C, etc.)

> **Important**
>
> Any funds you withdraw for non-qualified expenses will be taxed at your income tax rate plus a 20% tax penalty if you're under age 65. After age 65, you pay taxes but no penalty.

Documentation is Key

An HSA can be used for a wide range of health care services within the limits established by law. Be sure you understand what expenses are HSA qualified, and be able to produce receipts for those items or services that you purchase with your HSA. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified expenses had not been previously paid or reimbursed from another source, and
- The qualified expense had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Health Savings Account

An Health Savings Account (HSA) lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- No 'use-it-or-lose-it,' keep your HSA forever
- Create a healthcare emergency safety net
- Invest[1] your HSA tax-free, like a 401(k)

Annual tax saving potential[2]

$1,660	$830
Family plan	Individual plan

2024 IRS Contribution Limits	
$8,300 Family plan	$4,150 Individual plan
Members 55+ can contribute an extra $1,000	

See how much you can save

HealthEquity.com/Learn/HSA

[1]Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | [2]Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

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Common qualified medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies

Flexible Spending Account

National Benefit Services

FLEXIBLE BENEFITS PLAN

Washington County School District

Employer ID NBS302966

PLAN HIGHLIGHTS

Login at: my.nbsbenefits.com

Congratulations! Washington County School District has established a "Flexible Benefits Plan" to help you pay for your out-of-pocket medical expenses. One of the most important features of the Plan is that the benefits being offered are paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

DETERMINING CONTRIBUTIONS

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year.

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections if you have a "change in status". Please refer to your Summary Plan Description for a change in status listing.

GENERAL PLAN INFORMATION

Plan Year End:…………………………………….............July 31st
Run-out Period:……………………………………..…….....…90 Days
.
Maximum Medical Limit……………..…...…Current IRS limit $3,200
…See Code Section 125(i)(2) or current enrollment information

Maximum Dependent Care Limit:……..………………..……..$5,000

Health FSA Carryover…Up to $640 following the Plan run-out

WHEN AM I ELIGIBLE TO PARTICIPATE

If you work 30 hours or more each week for the company, you will be eligible to join the Plan following your date of employment.

You will enter the Plan on the first day of the month following the day in which you meet the above eligibility requirements.

WHAT TYPE OF BENEFITS ARE AVAILABLE

Under our Plan, you can choose the following benefits. Each benefit allows you to save taxes at the same time because the amount you elect is set aside on a pre-tax basis.

Health Flexible Spending Account:
The Health Flexible Spending Account (FSA) enables you to pay for expenses allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan. The most that you can contribute to your Health FSA each Plan Year is set by the IRS. This amount can be adjusted for increases in cost-of-living in accordance with Code Section 125(i)(2).

Please note: If you participate in a Health Savings Account (HSA) benefit because you are enrolled in a HDHP, you **cannot** participate in the Full Health Flexible Spending Account benefit, but you **can** participate in the Limited Health Flexible Spending Account Benefit.

Health Savings Account:
A Health Savings Account allows participants insured by a Qualified High Deductible Health Plan to save for deductibles and other expenses not covered under the Plan. If you participate in this benefit you **cannot** participate in the Health Flexible Spending Account benefit, only a Limited FSA.

Limited Health Flexible Spending Account:
If you participate in an HSA you may also participate in a Limited Health Flexible Spending Account and be reimbursed for out-of-pocket dental and/or vision expenses incurred by you and your dependents. Once you satisfy the statutory deductible you may be reimbursed for medical expenses that are allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical Plan. Please refer to your SPD for the current statutory amount. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses.

NBS Welfare Benefit Service Center

P.O. Box 6980
West Jordan, UT 84084
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

Washington County School District Cafeteria Plan
Washington County School District

Plan Contact Person:
Tammara Robinson
121 West Tabernacle
St. George, Utah 84770
(435) 673-3553

Dependent Care Flexible Spending Account:
The Dependent Care Flexible Spending Account (DCAP) enables you to pay for out-of-pocket, work-related dependent day-care cost. Please see the Summary Plan Description for the definition of eligible dependent. The law places limits on the amount of money that can be paid to you in a calendar year. Generally, your reimbursement may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns; (b) your taxable compensation; (c) your spouse's actual or deemed earned income. Also, in order to have the reimbursements made to you and be excluded from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense and proof that the expense has been incurred.

Premium Expense Plan:
A Premium Expense portion of the Plan allows you to use pre-tax dollars to pay for specific premiums under various insurance programs that we offer you.

Please note: Policies other than company sponsored policies (i.e. spouse's or dependents' individual policies etc.) may not be paid through the Flexible Benefits Plan. Furthermore, qualified long-term care insurance plans may not be paid through the Flexible Benefits Plan.

HOW DO I RECEIVE REIMBURSEMENTS
During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. You can get a claim form at www.NBSbenefits.com.

Claim forms must be submitted no later than 90 days after the end of the Plan Year for the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. Any contributions remaining at the end of the Plan Year will be forfeited. However, if you have unused contributions in your Health Flexible Spending Account following the Plan run-out period, you may roll up to $640 to the new plan year. If you move to a HDHP and HSA, any remaining balance up to $640 in your Health Flexible Spending Account will be moved into a Limited Health Flexible Spending Account due to eligibility in an HSA. Funds can be used as indicated under Limited Health Flexible Spending Account above. Any amount above $500 in your Health FSA at the end of the Plan run-out period will be forfeited.

NBS Flexcard – FSA Pre-paid MasterCard
Your employer may sponsor the use of the NBS Flexcard, making access to your flex dollars easier than ever. You may use the card to pay merchants or service providers that accept credit cards, so there is no need to pay cash up front then wait for reimbursement.

Orthodontic expenses that are paid fully up-front at the time of banding are reimbursable in full after the initial service has been performed and payment has been made. Ongoing orthodontia payments are reimbursable only as they are paid.

WHO ARE HIGHLY COMPENSATED & KEY EMPLOYEES
Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Please refer to your Summary Plan Description for more information. You will be notified of these limitations if you are affected.

Updated: 3/26/2024

Employees Save Big

Limited Purpose FSA

Savings on Payroll Taxes

With a Limited Purpose FSA, you can save an average of 30% on qualifed dental and vision expenses by using pre-tax dollars on out of pocket dental and vision expenses for you, your spouse, and dependents. Your election amount is available on day 1 of the plan year, giving you the ability to pay for these expenses immediately.

Maximize your tax savings and retirement preparation by enrolling in both an HSA and the Limited Purpose FSA.

Dental Expenses

- Cleaning
- Fillings
- Crowns
- Braces

Vision Expenses

- Eye Exams
- Contact Lenses
- Eyeglasses
- Vision Correction Procedures

**Your Limited Purpose FSA may open to a Full FSA after the HSA statutory deductible is met. Talk to your plan advisor to see if your Limited Purpose FSA has this feature.*

Dental

EMI

Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

DENTAL COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE
NOT INTENDED TO COVER ALL DENTAL EXPENSES
OUTLINE OF COVERAGE

Read Your Policy Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Group:	**Washington County School District (Plan #0832)**
Plan:	**Choice PPO**
Administered by:	**Educators Mutual Insurance Association, a Utah Company**
Effective Date:	**8/1/2024**
Benefit Year:	**Contract**
Plan Type:	**Contributory / Self Funded**

	In-Network (Advantage *Plus* Network)	In-Network (Premier Network)	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	**100%**	**100%**	**70% up to MAC***
Type 2 - Basic Fillings, Oral Surgery	**80%**	**80%**	**70% up to MAC***
Type 3 - Major Crowns, Bridges, Prosthodontics	**50%**	**50%**	**40% up to MAC***
Type 4 - Orthodontics Dependent children ages 7 through 18	**50%**	**50%**	**50%**
Adults	Discount Only	Discount Only	No Coverage
Endodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Sealants	Type 3 - Major	Type 3 - Major	Type 3 - Major
Space Maintainers	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Waiting periods			
Type 2 - Basic	None		
Type 3 - Major	Failure to enroll at first opportunity results in a 12 month waiting period		
Type 4 - Orthodontics			
Deductible	In and Out of Network Deductibles are Combined		
Per Person	$50.00	$50.00	$50.00
Family Max	$150.00	$150.00	$150.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3	Type 1, Type 2 & Type 3
Annual Maximum Per Person	$2,000.00	$1,500.00	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum	$1,000.00		
Network / Reimbursement Schedule	Advantage Plus Dentemax	Premier	MAC

Provisions / Limitations / Exclusions	
Exams (including Periodontal), Cleanings and Fluoride	2 per year
Fluoride	Any age
Sealants	Dependent children only
Space Maintainers	Up to age 17
Bitewing X-Rays	2 per year
Periapical X-Rays	Cpvered in Type 1
Panoramic X-Ray	1 every 3 years
Impacted Teeth	Covered in Type 2 - Basic
Anesthesia - (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 2 - Basic**
Anesthesia - (For children age 7 and under, once per year)	Covered in Type 2 - Basic**
Implants / Implant Abutments	Covered in Type 3 - Major
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth
Fillings on the same surface	1 every 18 months

* All Services are subject to EMI Health Maximum Allowable Charge (MAC). When using a Non-participating Provider, the insured is responsible for all fees in excess of the Maximum Allowable Charge (MAC).

** Anesthesia is not subject to waiting periods.

EMI HEALTH

The EMI Health Mobile App

Your benefits. Anytime. Anywhere.

Provider Search

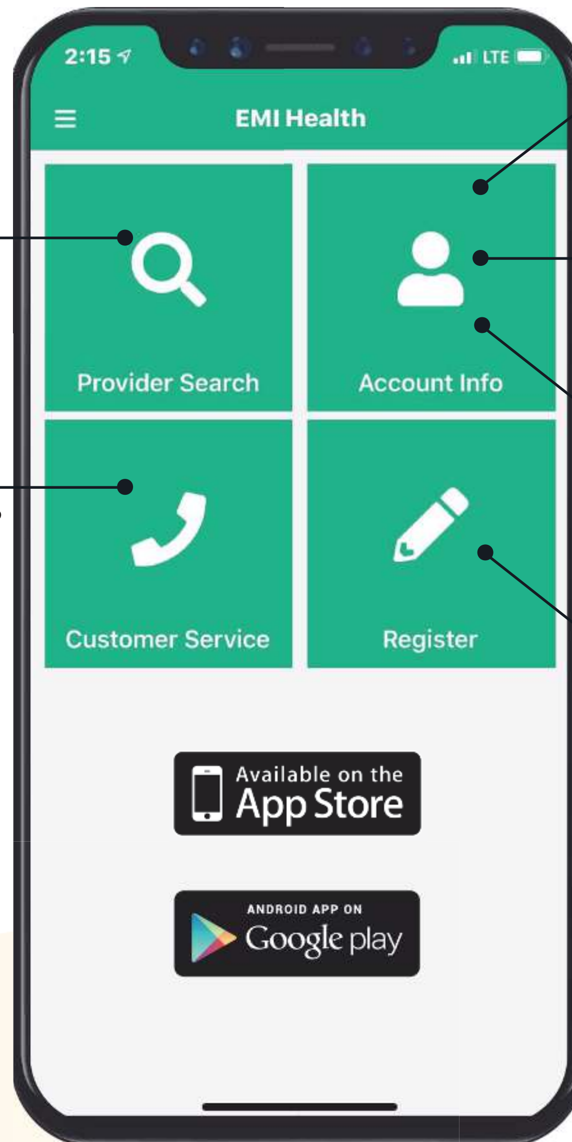
Find in-network providers and facilities.

Customer Service

Need to talk to a person?
No problem.
Call us from the app.

Other Features

- Access current and past issues of the Hope Health newsletter.
- Update your profile information like email address, password, or security questions.



ID Card

Access your ID Card from anywhere at any time.

EOBs

View your EOBs and search by person, service, date, and more.

Plan Information

View and download your plan grids so you always know the benefits you have.

Log in/Register

Download the app and log in using your My EMI Health username and password.

If you haven't registered your account, you can do so in the app or online at emihealth.com.

Scan this QR code with your phone to download.

Life and AD&D & Travel Assistance

Lincoln Financial

Washington County School District provides this valuable benefit at no cost to you.

All Full-Time Employees who are eligible for Employer Sponsored Medical Plan

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of $25,000 to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident.
- A cash benefit of $2,420 to you in the event of your spouse's death, plus an additional cash benefit if your spouse dies in an accident.
- A cash benefit of $2,420 to you in the event of your child(ren)'s death if your child is under 26 years of age.
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys®* services, which provide access to counseling, financial, and legal support services.
- *TravelConnect®* services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed voluntary life insurance information for details.

Additional details

Continuation of coverage for ceasing active work: You may be able to continue your coverage if you leave your job for reasons including and not limited to Family and Medical Leave, lay-off, leave of absence, leave of absence due to disability.

Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Continuation of coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 70, by an additional 15% of the original amount when you reach age 75, and an additional 15% of the original amount when you reach age 80. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

REMINDER: Please review your beneficiary(ies) to ensure they are up to date. It's good practice to review, and if necessary update, your beneficiary(ies) annually.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. EstateGuidance® and GuidanceResources® Online are trademarks of ComPsych® Corporation.

State limitations apply. Beneficiary Grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

Travel Connect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the state of New York and Washington. Access only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.
Not for use in New York or Washington.

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

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GP-LADD-FLI001_Z01

Washington County School District

Benefits At-A-Glance

All Full-Time Employees who are eligible
for the Employer Sponsored Medical Plan

Voluntary Life Insurance

The Lincoln Term Life Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death or if you die in an accident
- Provides a cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- Features group rates for employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee Life	
Coverage Options	Increments of $5,000
Maximum coverage amount	This amount may not exceed $500,000
Minimum coverage amount	$5,000
Guaranteed Life coverage amount	$450,000
Your coverage amount will reduce by 35% when you reach age 70; an additional 15% of the original amount when you reach age 75; and an additional 15% of the original amount when you reach age 80. Benefits end when you retire.	
Spouse Life The amount of Dependent Life Insurance coverage cannot be greater than 100% of the Employee Benefit.	
Coverage Options	Increments of $5,000
Maximum coverage amount	This amount may not exceed $300,000
Minimum coverage amount	$5,000
Guaranteed Life coverage amount	$50,000
Coverage amounts are reduced by 35% when you reach age 70; an additional 15% of the original amount when you reach age 75; and an additional 15% of the original amount when you reach age 80. Benefits end when you retire.	
Dependent Child(ren) Life	
Under 26 years of age	Increments of $2,500 not to exceed $10,000

What your benefits cover

Employee Coverage

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $450,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by two levels without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined or withdrawn, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Insurance Coverage Amount

- You can choose a coverage amount up to $500,000. Evidence of Insurability may be required for voluntary life coverage. See the Evidence of Insurability page for details.

Spouse Coverage - You can secure term life insurance for your spouse if you select coverage for yourself.

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $50,000 for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by two levels without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined or withdrawn, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Insurance Coverage Amount

- You can choose a coverage amount up to $300,000 for your spouse. Evidence of Insurability may be required.

Dependent Child(ren) Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself**.**

Guaranteed Life Insurance Coverage Options:

- You can choose a coverage amount up to $10,000 for your child(ren).

Additional Plan Benefits Included with Life Coverage

Waiver of Premium	Included
Portability	Included
Accelerated Death Benefit	Included
Conversion	Included

Benefit Exclusions

Like any insurance, this term life insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Questions? Call 800-423-2765 and mention Group ID: WASHINGSD.

REMINDER: Please review your beneficiary(ies) to ensure they are up to date. It's good practice to review, and if necessary update, your beneficiary(ies) annually.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

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State limitations apply. Beneficiary Grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

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The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the state of New York and Washington. Access only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.
Not for use in New York or Washington.

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GP-OPVL-FLI001_Z01

Monthly Voluntary Life Insurance Premium
Calculate Your Premium.

Group Life Rates for You

Employee Age Range	Life Premium Rate
0 - 24	$0.048
25 - 29	$0.057
30 - 34	$0.057
35 - 39	$0.076
40 - 44	$0.095
45 - 49	$0.143
50 - 54	$0.209
55 - 59	$0.352
60 - 64	$0.418
65 - 69	$0.684
70 - 74	$1.280
75 +	$1.960

Group Life Rates for Your Spouse

Employee Age Range	Life Premium Rate
0 - 24	$0.048
25 - 29	$0.057
30 - 34	$0.057
35 - 39	$0.076
40 - 44	$0.095
45 - 49	$0.143
50 - 54	$0.209
55 - 59	$0.352
60 - 64	$0.418
65 - 69	$0.684
70 - 74	$1.280
75 +	$1.960

Group Life Rates for your Dependent Child(ren)

Child(ren) Life Premium Rate, per $1,000
$0.090

One affordable monthly premium covers all of your eligible dependent children.

Note: To be eligible for coverage, a spouse or dependent child cannot be confined on the date the increase or addition is to take effect, it will take effect when the confinement ends.

Based on Employee Age

Calculate Your Cost

Use the appropriate rate provided in the tables above to calculate your cost based on the amount of coverage you select. The following example calculates the monthly cost for a 36-year-old employee who would like to purchase $100,000 in employee voluntary term life insurance coverage.

Calculation Example		Example	You
Step 1	Using the table above, enter the rate that corresponds with your age.	$0.076	
Step 2	Enter the desired coverage amount in dollars.	$100,000	
Step 3	Enter the desired coverage amount in increments of $1,000. *To calculate, divide the coverage amount by $1,000.*	100	
Step 4	Calculate the monthly cost. *Multiply Step 1 by Step 3.*	$7.60	

Note: Rates are subject to change and can vary over time.

Please see prior page for product information.

Washington County School District

Benefits At-A-Glance

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

The Lincoln Voluntary AD&D Insurance plan:

- Provides a cash benefit to your loved ones if you die in an accident
- Provides a cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- Features group rates for employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support
- Includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

All Full-Time Employees Eligible for
Employer Sponsored Medical Plan

Employee AD&D	
Coverage options	Increments of $5,000
Maximum coverage amount	This amount may not exceed $500,000

Your employee AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 25% of the original amount when you reach 75, and an additional 15% of the original amount when you reach 80. Benefits end when you retire.

Family AD&D

You must enroll in family AD&D coverage to elect spouse or child(ren) family AD&D coverage. You may choose to cover your dependent spouse and child(ren) under the family AD&D plan. All eligible dependents will be covered. The spouse and child(ren) family AD&D coverage is a percentage of the employee coverage amount and is based on the employee's dependents.

Spouse coverage without child(ren)	60% of your coverage amount
Spouse coverage with children	50% of your coverage amount
Child(ren) coverage without spouse	15% of your coverage amount for each dependent child
Child(ren) coverage with spouse	10% of your coverage amount for each dependent child

Your spouse AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 15% of the original amount when you reach age 75, and an additional 15% of the original amount when you reach age 80. Benefits end when you retire.

Benefit exclusions

Like any insurance, this AD&D insurance policy does have exclusions. Benefits will not be paid if death or dismemberment occurs as the result of:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Suicide, or suicide attempt, while sane or insane
- Active participation in a riot
- Committing or attempting to commit a felony
- Disease, bodily or mental illness, or medical or surgical treatment thereof
- Infections
- Controlled substances voluntarily taken, ingested, or injected, unless prescribed or administered by a physician
- Serving on full-time active duty in the Armed Forces of any country or international authority
- The presence of alcohol in the covered person's blood which raises the presumption that the covered person was under the influence of alcohol and contributed to the cause of the accident

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

REMINDER: Please review your beneficiary(ies) to ensure they are up to date. It's good practice to review, and if necessary update, your beneficiary(ies) annually.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. EstateGuidance® and GuidanceResources® Online are trademarks of ComPsych® Corporation.

State limitations apply. Beneficiary Grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the state of New York and Washington. Access only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services. Not for use in New York or Washington.

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

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GP-VLADD-FLI001_Z01

Voluntary AD&D insurance

Calculate your premium.

Calculate your cost

Use the table below to determine your cost based on the amount of coverage you select. The following example calculates the monthly cost for an employee who would like to purchase $100,000 in employee optional AD&D insurance coverage.

Calculation example		Example	You
Step 1	Monthly rate	$0.022	
Step 2	Enter the desired coverage amount in dollars.	$100,000	
Step 3	Enter the desired coverage amount in increments of $1,000. To calculate, divide the coverage amount by $1,000.	100	
Step 4	Calculate the monthly cost. Multiply step 1 by step 3.	$2.20	

Note: Rates are subject to change and can vary over time.

Monthly premium calculation for your family

Use the table below to determine your cost based on the amount of coverage you select. The following example calculates the monthly cost for an employee who would like to purchase $50,000 in optional family AD&D insurance coverage.

Calculation example		Example	You
Step 1	Monthly rate	$0.050	
Step 2	Enter the desired coverage amount in dollars.	$50,000	
Step 3	Enter the desired coverage amount in increments of $1,000. To calculate, divide the coverage amount by $1,000.	50	
Step 4	Calculate the monthly cost. Multiply step 1 by step 3.	$2.50	

Note: Rates are subject to change and can vary over time.

Please see prior page for product information.
Voluntary AD&D insurance at a glance

Lincoln Financial Group®

Caring support and assistance when you travel

TravelConnect® services offer help, comfort, and reassurance – helping make travel less stressful. If you're enrolled in life and/or AD&D insurance, you and your loved ones can count on *TravelConnect* services 24 hours a day, 7 days a week.

TravelConnect services you can count on during an emergency.*

You'll have dedicated support if you face an emergency when you're 100 or more miles from home. *TravelConnect* helps with:

- Arranging travel if you're injured and need emergency medical evacuation to a medical facility.
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort.
- Planning and paying for a safe evacuation because of a natural disaster or a political or security threat.
- Arranging transportation of a deceased traveler.
- Securing emergency pet boarding and/or return and vehicle return.

Ongoing support when you're far from home.

From planning the trip until flying home, these *TravelConnect* services can help you on your way.

- Medical record requests
- Medication and vaccine delivery
- Medical, dental, and pharmacy referrals
- Corrective lenses and medical device replacement
- Legal consultation
- Recovering lost or stolen documents or luggage
- ID recovery assistance
- Language translation services
- Destination information

TravelConnect®

GLOBAL ASSISTANCE PROGRAM

Provided by On Call International
Medical, security, and travel assistance services
for participants traveling 100+ miles from home

Visit mysearchlightportal.com and enter Group ID #: LFGTravel123 for access to plan documents, international calling instructions, and destination information.

LFE-TRVFE-FLI001

For a complete list of *TravelConnect* services, go to mysearchlightportal.com and enter your Group ID: LFGTravel123.

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations.

*On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the states of New York and Washington. Access only program available in Missouri and Texas. Benefits provided under the Access only program exclude paid services.

Not for use in New York and Washington.

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LCN-3758527-091321
MAP 9/21 **Z02**
Order code: LFE-TRVFE-FLI001

If you need medical, security, or travel assistance, regardless of the nature or severity of your situation, contact On Call 24 hours a day:

Call collect from anywhere in the world:
+1-603-328-1955
Call toll free from U.S. or Canada:
866-525-1955
Email: mail@oncallinternational.com

Global Assistance Services must be coordinated and approved by On Call in order to be covered.

See your plan description for full terms and conditions of the services offered in your plan.

On Call International
A member of the Tokio Marine HCC group of companies

Disability

Lincoln Financial

Lincoln Financial Group®

Full-Time Employees of Washington County School District

Benefits At-A-Glance

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 26 weeks due to injury, illness, surgery, or recovery from childbirth
- Provides a partial cash benefit if you can only do part of your job or work part time
- Features group rates for Washington County School District employees
- Offers a fast, no-hassle claims process

Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to $1,500 per week
Sickness elimination period	14 days
Accident elimination period	14 days
Maximum coverage period	26 weeks

Sickness Elimination Period

- You must be out of work for 14 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 15.

Accident Elimination Period

- You must be out of work for 14 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 15.

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

No Benefits Reduction

- Your short-term disability benefits can coordinate with income from other sources, such as any state disability benefits, continued income or sick pay from your employer, or Workers' Compensation, during your disability—your benefit will not be reduced by this other income.

The Lincoln National Life Insurance Company

Open Enrollment

- When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage.
- If you decline this coverage now and wish to enroll later, a health examination may be required.

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

Questions? Call 800-423-2765 and mention Group ID: WASHINGSD.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

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STD-ENRO-BRC001-UT

Voluntary Short-term Disability Premium
Here's how little you pay with group rates.

Your estimated monthly premium is determined by multiplying your weekly salary amount (up to $2,250) by your age-range premium factor. If your weekly salary exceeds $2,250, multiply $2,250 by your premium factor.

$ ____________________
weekly salary

X ____________________
premium factor

=$ ____________________
monthly premium

Age Range	Premium Factor
25 - 29	0.02160
30 - 34	0.02093
35 - 39	0.01953
40 - 44	0.01953
45 - 49	0.02160
50 - 54	0.02440
55 - 59	0.02927
60 - 64	0.03487
65 - 69	0.04047
70 - 74	0.04460
75 - 99	0.04740

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001-UT

Washington County School District provides this valuable benefit at no cost to you.

All Full-Time Provisional and Career Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to $10,000) starting 180 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
    - Program Services include:
    - Unlimited, 24/7 access to information and referrals
    - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
    - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
    - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

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Insurance products (policy series GL3001) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations. Limitations and exclusions apply.

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Vision

EMI

Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

Group:	**Washington County School District (Plan #0832)**
Plan:	**VSP 100**
Effective Date:	**8/1/2024**
Plan Type:	**Voluntary**

	In-Network	Out-of-Network
Network	VSP Choice Plus	
WellVision Exam	Not Covered	Not Covered
Lenses (Glass or Plastic)		
Single Vision	$0 Co-pay	Up to $30
Lined Bifocal	$0 Co-pay	Up to $50
Lined Trifocal	$0 Co-pay	Up to $65
Lenticular	$0 Co-pay	Up to $100
Lens Options		
Progressive (Standard no-line)	$0 Co-pay	Up to $50 (In lieu of Lined Bifocal reimbursement)
Premium Progressive Options	$95-$105 Co-pay	
Custom Progressive Options	$150-$175 Co-pay	
Plastic Gradient Dye	$17 Co-pay	N/A
Solid Plastic Dye	$15 Co-pay	
Photochromic Lenses	$75 Co-pay	
Polycarbonate for Adults	$31 Co-pay SV/$35 Co-Pay Multifocal	
Polycarbonate for Children (under 18)	$0 Co-pay	
Coatings		
Scratch Resistant Coating	$17 Co-pay	N/A
Anti-Reflective Coating	$41 Co-pay	
UV Protection	$16 Co-pay	
Additional lens enhancements	Up to 25% Discount	
Frames		
Allowance Based on Retail Pricing	$100 Allowance at any VSP doctor or $100 at Costco, Sam's Club or Walmart	Up to $70
Additional Pairs of Glasses**	Up to 20% Off Retail	N/A
Elective Contact Lenses In Lieu of Frame & Lenses		
Elective contact lens fitting, evaluation services and prescription contact lenses are covered up to plan allowance. 15% discount given off contact lens fitting and evaluation services, excluding materials.	$100 Allowance	Up to $85
Frequency		
Lenses, Frame or Contacts	Every Calendar Year	
Refractive Surgery		
LASIK***	Up to $500 in Savings	Not Covered

Monthly Rates	**Voluntary**
Employee	$4.80
Two Party	$9.30
Family	$14.70

Notes

** 20% discount off unlimited additional pairs of glasses offered through any VSP Choice Providers within 12 months of last covered eye exam.

*** Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and IntraLase3

Underwritten by: Educators Mutual Insurance Association, a Utah Company

Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

Group: Washington County School District (Plan #0832)
Plan: VSP 130
Effective Date: 8/1/2024
Plan Type: Voluntary

	In-Network	Out-of-Network
Network	VSP Choice Plus	
WellVision Exam	Not Covered	Not Covered
Lenses (Glass or Plastic)		
Single Vision	$0 Co-pay	Up to $30
Lined Bifocal	$0 Co-pay	Up to $50
Lined Trifocal	$0 Co-pay	Up to $65
Lenticular	$0 Co-pay	Up to $100
Lens Options		
Progressive (Standard no-line)	$0 Co-pay	Up to $50 (In lieu of Lined Bifocal reimbursement)
Premium Progressive Options	$95-$105 Co-pay	
Custom Progressive Options	$150-$175 Co-pay	
Plastic Gradient Dye	$17 Co-pay	N/A
Solid Plastic Dye	$15 Co-pay	
Photochromic Lenses	$75 Co-pay	
Polycarbonate for Adults	$31 Co-pay SV/$35 Co-Pay Multifocal	
Polycarbonate for Children (under 18)	$0 Co-pay	
Coatings		
Scratch Resistant Coating	$17 Co-pay	N/A
Anti-Reflective Coating	$41 Co-pay	
UV Protection	$16 Co-pay	
Additional lens enhancements	Up to 25% Discount	
Frames		
Allowance Based on Retail Pricing	$130 Allowance at any VSP doctor or $130 at Costco, Sam's Club or Walmart	Up to $80
Additional Pairs of Glasses**	Up to 20% Off Retail	N/A
Elective Contact Lenses In Lieu of Frame & Lenses		
Elective contact lens fitting, evaluation services and prescription contact lenses are covered up to plan allowance. 15% discount given off contact lens fitting and evaluation services, excluding materials.	$130 Allowance	Up to $115
Frequency		
Lenses, Frame or Contacts	Every Calendar Year	
Refractive Surgery		
LASIK***	Up to $500 in Savings	Not Covered

Monthly Rates	Voluntary
Employee	$5.60
Two Party	$10.90
Family	$17.30

Notes

** 20% discount off unlimited additional pairs of glasses offered through any VSP Choice Providers within 12 months of last covered eye exam.

*** Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and IntraLase3

Underwritten by: Educators Mutual Insurance Association, a Utah Company

VSP Choice Plus

Awesome coverage and easy to use benefits.

1. **Choose a VSP provider**
2. **Give your EMI Health ID number**
3. **VSP does the rest!**

No claim forms.
No paperwork.
It's that easy!

Choice Plus Network

- Costco
- Wal-Mart
- Sam's Club
- Shopko
- Visionworks
- Eye Masters

Plans include Exams & Hardware

EMI.MKTG.VSPCHOICEPLUS.1218.1171

Extra Savings

Here are some extra perks!

- All non-covered lens options are cost-controlled, averaging 20-25% off retail prices.
- Most popular lens options have fixed co-pay for photochromic, polycarbonate, scratch anti-reflective, UV coatings, and more.
- 20% savings on frame cost over the frame allowance.
- 20% savings on complete pairs within the last 12 months of exam.
- 15% savings on contact lens evaluation & fitting fees.
- Laser vision correction.
  - Average 15% off the regular price or 5% off the promotional prices; only available from contracted facilities.
  - After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Out-of-Network (OON) Claim Submittal Options

If you do visit an out-of-network provider, you have options

1 Provider Level - Assignment of Benefit Option (AoB)

- Provider bills VSP for OON reimbursement.
- Member pays overage at the time of service.

---

2 Member Level - Submitting for Reimbursement

- Member pays provider in full and sends itemized receipt to VSP for reimbursement to:

VSP

PO Box 385018

Birmingham, AL 35239-5018

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3 Online Submission - VSP.com

- Member signs in and completes online form and submits electronically.

Getting Started With VSP

Create an account. Schedule a visit. Save money.

1 Create an Account
Get started by creating a vsp.com account and opting to receive information about your benefits.

Already have an account? Log in to review your coverage before your eye exam.

2 Schedule an Eye Exam
Find the eye care provider who is right for you at vsp.com. We recommend you get an eye exam once a year. Don't forget to check out the featured frame brands to find your perfect style.

3 See Your Savings
Log into your account on vsp.com to view your personalized Savings Statement to see how much you saved.

4 Re-Enroll in VSP
Vision insurance is a simple benefit option to review and select. Still on the fence? Here's one more reason - members save an average of $362 when they select VSP.

Did You Know?

- You have access to more than 30,000 network doctors.
- 9 out of 10 members reported satisfaction in the past five years.*
- As a member, you'll get exclusive member extras that you won't find anywhere else.

Visit **vsp.com/memberjourney** to check out a fun, interactive version of your VSP journey.

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Voluntary Benefits

Voya
Accident, Critical Illness & Hospital Indemnity

Accident

Voya

Accident insurance can help provide you with a cushion to help cover expenses and living costs when you get hurt. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious or even not-so-serious injury. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

With Voya Group Accident Insurance you can have peace of mind knowing:

- Coverage is guaranteed issue - no evidence of insurability required at initial enrollment.
- Benefits are paid directly to you unless assigned to someone else.
- Benefits are paid in addition to any other coverage.

Plan Features	Benefit Amounts
Accident Physician Treatment	$90
X-ray	$75
Ambulance	$360 Ground / $1,500 Air
ER Service/Urgent Care	$225
Dislocation/Fracture Benefit	Up to $10,000
Hospital Confinement/Daily Benefit	$1,250 Admission / $275 Daily
Accident Follow-Up Visits	$90
Lacerations	Up to $480
Burns *(Depends on severity)*	Up to $15,000
AD&D	Up to $50,000
Wellness Benefit	$75 Employee and Spouse $37.50 for up to 4 Children

Accident Plan Monthly Premiums

Employee Only	$9.97
Employee & Spouse	$15.98
Employee & Child(ren)	$22.15
Family	$26.96

Critical Illness

Voya

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis.

With Voya Group Critical Illness Insurance you can have peace of mind knowing you're covered in the event of:

Covered Illness / Condition	Benefit
Heart Attack	100%
Cancer	100%
Stroke	100%
Major Organ Transplant	100%
Type 1 Diabetes	100%
Severe Burns	100%
Benign Brain Tumor	100%
Permanent Paralysis	50%
Loss of Sight, Hearing or Speech	50%
Advanced Dementia (including Alzheimer's)	50%
Coma	50%
Coronary Artery Bypass Surgery	25%
Carcinoma In-Situ	25%
Open Heart Surgery/Valve Replacement	25%

Covered Illness / Condition	Benefit
ICD Placement	25%
Bone Marrow Transplant	25%
Stem Cell Transplant	25%
Multiple Sclerosis	25%
ALS	25%
Parkinson's Disease	25%
Infectious Disease	25%
Transient Ischemic Attacks	10%
Ruptured or Dissecting Aneurysm	10%
Abdominal/Thoracic Aortic Aneurysm	10%
Coronary Angioplasty	10%
Pacemaker Placement	10%
Transcatheter Heart Valve Replacement or Repair	10%
Skin Cancer	10%

Critical Illness

Voya

Plan Features	Employee	Spouse	Dependent
Coverage	$15,000 or $30,000	50% of Employee's Elected Benefit	50% of Employee's Elected Benefit
Guarantee Issue	$30,000	$15,000	$15,000
Pre-Existing	None	None	None
Wellness Benefit *Must complete a health screening*	$50	$50	$25 per child *Up to four children*

Critical Illness Coverage Rates

EE: $15,000 SP: $7,500 Children: $7,500

	Non-Tobacco User				Non-Tobacco User			
Age	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
<30	$4.05	$6.08	$4.05	$6.08	$6.45	$9.68	$6.45	$9.68
30-39	$7.05	$10.58	$7.05	$10.58	$11.85	$17.78	$11.85	$17.78
40-49	$13.80	$20.70	$13.80	$20.70	$28.35	$42.53	$28.35	$42.53
50-59	$24.45	$36.68	$24.45	$36.68	$48.60	$72.90	$48.60	$72.90
60+	$39.00	$58.50	$39.00	$58.50	$77.40	$116.10	$77.40	$116.10

EE: $30,000 SP: $15,000 Children: $15,000

	Non-Tobacco User				Non-Tobacco User			
Age	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
<30	$8.10	$12.15	$8.10	$12.15	$12.90	$19.35	$12.90	$19.35
30-39	$14.10	$21.15	$14.10	$21.15	$23.70	$35.55	$23.70	$35.55
40-49	$27.60	$41.40	$27.60	$41.40	$56.70	$85.05	$56.70	$85.05
50-59	$48.90	$73.35	$48.90	$73.35	$97.20	$145.80	$97.20	$145.80
60+	$78.00	$117.00	$78.00	$117.00	$154.80	$232.20	$154.80	$232.20

Spouse age and tobacco status are based of the employee age and tobacco state.
Child Embedded in Employee Rate

Hospital Indemnity

Voya

An inpatient stay in the hospital is expensive, and there may be additional costs unrelated to your stay such as having a baby or missing work. Hospital Indemnity coverage pays a cash benefit when you are admitted for an inpatient stay for a minimum of __ confinement hours. You can use the monies to pay for medical bills not covered by insurance, or in any way you see fit.

With Voya's Group Hospital Indemnity Insurance:

- Benefits from a Hospital Indemnity plan can be used to assist you in paying deductibles, coinsurance, out-of-network costs, daily living expenses, etc.
- Benefits are paid regardless of other coverage and this plan is compatible with Health Savings Accounts.

Benefits Include:

Guarantee Issue	Yes
Pre-Existing	None
Maternity Waiting Period	None
First Day Hospital Confinement	$1,200
Daily Hospital Benefit *Up to 31 Days*	$200 per day
Intensive Care *Up to 31 days*	$400 per day
Rehabilitation Unit *Up to 31 days*	$100 per day
Wellness	$50 Employee and Spouse $25 per child up to 4 children

Hospital Indemnity Monthly Premiums

Employee Only	$24.86
Employee & Spouse	$50.98
Employee & Child(ren)	$43.14
Family	$69.26

How to file a benefits claim

For certificate or policy holders of Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance Coverage.

Group Policy Name: Washington County School District

Group Policy Number: 728497

Scan here for the WCSD Voya Website and to access Voya benefit summaries.

Online submission via the Voya Claims Center

Step 1: Visit the online Claims Center at voya.com/claims or https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict and click on "Start A Claim".

Step 2: Complete the questionnaire.
This generates a custom claim form package for you.

- If you are filing a Wellness Benefit claim, this process is completed online during this questionnaire. No claim form is necessary. Simply submit your claim at the end of the questionnaire.

Step 3: Download your claim form package, if applicable.

Step 4: Complete the form package, if applicable, or go to Step 5.
Have each form completed by the appropriate party, as outlined in the claim form package.

Step 5: Gather additional documents.
Collect any additional supporting documents, as instructed on the claim form "for you".

Step 6: Submit.
Using your preferred submission method, submit your completed and signed forms, as well as any supporting documents.

- To submit your claim **online** via a secure upload, visit voya.com/claims and click on Step 2, "Submit Your Forms".
- To **mail** or **fax** your submission, see the top of your custom claims form package.

Questions about the claim process?

For **Accident, Critical Illness, Specified Disease and/or Hospital Confinement Indemnity Insurance claims**, call **1-877-236-7564.**

Insurance products are issued by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Voya Employee Benefits is a division of ReliaStar Life Insurance Company. Product availability and specific provisions may vary by state and employer's plan.

Washington County School District, Group #00728497, Acct #0001 Date Prepared: 03/03/2022

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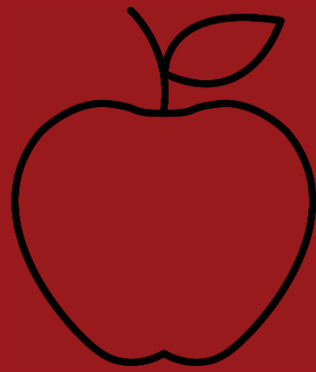
ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

PLAN
INVEST
PROTECT

VOYA FINANCIAL



Wellness

Washington County School District Wellness Program

Did you know that about 70% of costs in medical care in the US are attributed to chronic disease? The good news is that healthy lifestyle choices are highly associated with reduced risk of developing chronic conditions such as heart disease, diabetes, metabolic syndrome, and more.

The District believes our employees and associates are our greatest asset. We also believe the greatest asset any individual can have is their health. We value your health and strive to continue identifying programs and tools that can assist you in managing your overall well-being.

What does our wellness program offer?

Our wellness program is a participatory-based program that offers a connection of paths, knowledge, and action to help provide the tools for you to take steps towards better health, all while offering choice and diversity, healthcare community support, incentive prizes, personalization, preventive care, social networking, and spotlights.

- **Monthly Wellness Theme:** We currently distribute weekly materials on our Wellness Wednesdays based on a wellness-related theme each month. These include preventive care, physical health, emotional well-being, financial wellness, stress management, healthcare community support, and more.
- **Monthly Initiative:** We aim to get active, seek balance, fuel your health, and work together! We have established weekly initiatives through mini-challenges to help maintain and improve well-being. We offer mini-challenge opportunities in various formats, such as wellness recordings, newsletters, flyers, health-related quizzes, in-person events, and more.

Rewards

Employees and their spouses who participate and complete mini-challenge requirements will be eligible for our monthly prize drawings. Don’t miss out on the opportunity to improve your well-being while being rewarded!

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the **GuidanceNow**℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow** mobile app, or call **888-628-4824**.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

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LCN-4917687-082422
MAP 9/22 **Z04**
Order code: LTD-EAPEE-FLI001

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*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  username: LFGSupport password: LFGSupport1
- Download the GuidanceNowSM mobile app
- Call 888-628-4824

Get started with your free online mental health benefit

Get back to feeling like you! Your psychological well-being can affect your physical health, relationships, and work performance. Tava's network of vetted therapists helps you step out of the fog, and get back to a happier, more fulfilled you.

Tava Health is a free, confidential mental health benefit available to all WCSD employees (full-time and part-time) and on-call/substitute contract workers. The benefit provides up to 15 free sessions annually with licensed clinicians through Tava's secure, web-based technology platform. All you need for a live, video-based session is reliable internet access and a connected device with a camera (smartphone, computer, or tablet).

Free to use
You can get started and use up to 15 sessions (per person per year) at no cost to you.

Convenient
Self-scheduled online video sessions means you get care whenever works best for you: days, nights, or weekends.

Confidential
We don't tell your employer who used the service. Your identity and anything you discuss is confidential.

Effective
Tava's clinicians are licensed, vetted, and use evidence-based treatments, so you can achieve your mental health goals.

Whether you're feeling stressed, stuck, or burdened with something else, Tava can help. Support is available for a range of issues such as:

Addiction
Anxiety
Depression
Eating disorders
Family issues
Grief and loss
LGBTQ+ issues
Life changes
Postpartum issues
PTSD
Trauma
Relationship issues
Work pressure
Stress
and more...

Schedule your first appointment today at
care.tavahealth.com

FAQ

Frequently Asked Questions

Is this service really free?
Yes! The costs of your first 15 sessions will be completely covered by your employer. Once you have used your free sessions, you can continue therapy by paying for it out of pocket.

What if I would like more more sessions?
Once an individual has used their covered sessions, there are several ways in which they can continue care. Many Tava therapists are credentialed with one or more insurance providers, so some or all of the cost of your additional sessions may be covered by insurance. Individuals can also pay for sessions out of pocket using debit or credit card or FSA, HSA, or HRA funds. The out-of-pocket cost of your sessions is $125 per session (this price is valid through 07/31/25).

Do Tava sessions count toward my insurance plan's deductible or out-of-pocket maximum?
Your use of sessions sponsored by your employer does not impact your deductible or out-of-pocket maximum. Costs of additional sessions that you choose to cover with your insurance apply toward your deductible and out-of-pocket maximum according to your insurance plan.

Who is eligible to use this service?
The Tava Health benefit is available to all WCSD employees, including full-time, part-time and on-call/substitute contract workers.

Is this service confidential?
Yes. Written records of all services are kept private and are unavailable to employers or others without the written consent of the identified patient (or legal guardian) unless disclosure of information is required by law or court order.

Can my employer see who is using Tava?
No. Employers do not have access to individual usage data. Any usage data that Tava shares with your employer is always de-identified and aggregated, protecting confidentiality and the identities of our individual clients.

Will my personal information be kept safely?
Yes. All personally identifiable information is stored in a secure, HIPAA-compliant database and will never be sold, shared, or transmitted for any reason.

Is this service available after business hours?
Yes. Tava's therapists have availability that extends beyond normal business hours. For current appointment availability, please visit care.tavahealth.com.

What if I need help immediately?
If you have an emergency or urgent matter, call the suicide hotline at 988, go to www.suicidepreventionlifeline.org, visit your nearest emergency room, or call 911.

How will I talk with my therapist?
Therapy sessions are delivered via video chat through Tava's online portal. All you need is a connected device with a camera (e.g., computer, smartphone, tablet). This means your sessions can take place wherever is most convenient and comfortable for you. We recommend choosing a quiet, private location with reliable, high-speed Wi-Fi for your visits.

What are the qualifications of my therapist?
Therapy sessions are provided by licensed masters-level or doctoral-level mental health professionals. Licensure requirements and specific titles vary by state. We verify each clinician's credentials and require their licensure be maintained in good standing.

What kind of therapy does Tava provide?
Tava's therapists provide talk therapy (i.e. psychotherapy) to help you identify ways to understand, manage, and resolve problems, including unhealthy thought patterns and behaviors. Therapists cannot prescribe medications.

What issues does Tava help resolve?
Tava has therapists who understand and treat many types of issues. See a comprehensive list of issues our therapists often address on the previous page of this document. If you are wondering whether Tava can help you, schedule a free, initial consultation at care.tavahealth.com.

Will my therapist and I be a good match?
Before your first visit, you will fill out a questionnaire that will help Tava suggest therapists for you. If at any time you feel your therapist is not a great fit, it's easy to change therapists. This relationship is a key determinant to the success of therapy.

Is online, video-based therapy effective?
Yes. Research has shown that online, video-based therapy is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care, and patient satisfaction. In 2018, the American Psychiatric Association issued the following statement in support of telemental health: "Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law."

Schedule your first appointment today at
care.tavahealth.com

Lincoln Financial Group®

Because life doesn't always go as planned.

No matter how well you plan, unexpected challenges arise. When they do, help and support are nearby—thanks to *LifeKeys*® services from Lincoln Financial Group.

LifeKeys services include:

Discounts on shopping and entertainment

GuidanceResources® includes 24/7 online access to the Working Advantage discount network. You can save up to 60% on a variety of products and services, including electronics, health and fitness, Broadway shows, and much more. Discounts are also available in the GuidanceNow mobile app, available in the Apple App Store and on Google Play.

Help with important life matters

You'll find support tools and advice on a wide range of topics, including legal, financial, family, and career, on GuidanceResources online. Stay in the know on matters that impact your personal and professional life.

Protection against identity theft

Identity theft is widespread, and everyone is vulnerable. *LifeKeys* includes an online resource for information that can help you recognize and prevent identity theft — and restore your good name should your identity be compromised.

Online will preparation

Creating a will allows you to make vital decisions ahead of time, including naming a guardian for your children or designating who will receive your property and assets after you pass away. Without a will, state officials will distribute your estate. *EstateGuidance*® offers a secure, efficient way to create and execute a will so you can rest easy knowing you've planned ahead for your family.

Guidance and support for your beneficiaries

LifeKeys is a comprehensive program that offers resources to help your loved ones address a range of common concerns should they experience a loss. Services include grief counseling, financial and legal advice, and support when coping with the challenges of day-to-day life. Services are detailed on page 2.

Your life and accidental death and dismemberment (AD&D) insurance policies include access to a wide range of services to help you and your loved ones navigate life's most important matters.

Help, guidance, and support for beneficiaries following a loss

The emotional impact of losing a loved one can be deep and long-lasting. All too often, financial or legal issues can add to the stress. *LifeKeys* services can be a welcome resource for your beneficiaries.

Your beneficiaries will have access to six in-person sessions for grief counseling, legal or financial information, and unlimited phone counseling. Services are available for up to one year after a loss.

Grief counseling — advice, information, and referrals on:

- Coping with loss
- Stress, anxiety, and depression
- Memorial planning information
- Concerns about family, including children and teens

Legal support — access to legal information on:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents for beneficiaries

Financial services — online resources and advice from financial specialists on:

- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Help with everyday life — comprehensive information on:

- Finding child care or elder care
- Financing a home
- Moving and relocation
- Making major purchases

Access *LifeKeys* services. Visit GuidanceResources.com, download the GuidanceNow mobile app, or call 855-891-3684. First-time users: enter web ID: LifeKeys.

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MAP 1/22 **Z04**
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State limitations apply. Beneficiary grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

Lincoln FuneralPrep: Help when you need it most

With many details to manage and decisions to make, the funeral planning process can be overwhelming. To help you every step of the way, we've partnered with **FuneralDecisions.com** to provide Lincoln FuneralPrep, a comprehensive planning service.

What is Lincoln FuneralPrep?

An online portal that provides a breadth of resources, Lincoln FuneralPrep can help with at-need planning or pre-planning — 24 hours a day.

At-need planning

When grieving the loss of a loved one, you're dealing with far more than a life insurance claim. Lincoln FuneralPrep helps you reduce the stress and uncertainty of making urgent decisions during an emotional time.

Pre-planning

Being prepared is one of the best things you can do for your family. In addition to providing pre-planning resources, Lincoln FuneralPrep can direct you to funeral professionals who can provide expert guidance and advice.

How to access Lincoln FuneralPrep

You can access Lincoln FuneralPrep in two ways.

1 Visit the self-service online portal: LincolnFuneralPrep.com/GPLife.

The online portal at LincolnFuneralPrep.com/GPLife includes a wealth of online funeral planning resources and services, including the ability to:

Search for funeral homes
Access an interactive list of funeral homes and cemeteries around the country. You can filter by location, service, and budget.

Access market information
Review price ranges and service options in your selected geographic location.

View guides and checklists
Organize your priorities, consider your options, and make informed decisions based on your preferences with our handy online guides and checklists.

2 Connect with a funeral planning consultant

Work with a funeral planning expert who can guide you through the pre-planning process and:

Help compare options
Get help comparing pre-planning options, even if you don't have a specific funeral home in mind.

Provide personalized service
Work with our experts to ensure your plans reflect your wishes and meet your objectives.

Offer objective guidance
Get guidance on planning options and various funding strategies.

During difficult times, we're here for you and your loved ones.

To learn more, visit LincolnFuneralPrep.com/GPlife.

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ADA 1/23 **Z08**
Order code: LFE-FNPRP-FLI001

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company.

Not available in New York.

Additional Information

Important Notices & Disclosures / URS

I'm New to URS. Now What?

Follow these simple steps to make your Tier 2 choice at **www.urs.org/us/steps**

As a new Tier 2 member, you have one year from your URS enrollment date to choose either the Hybrid Option (pension) or the 401(k) Option. The Hybrid Option is the default. Follow the QR code above or go to **www.urs.org/us/steps** for a checklist of simple steps to get started.

Step 1 Create a myURS Online Account

This is how you access and manage your URS benefits.
Choose your beneficiaries as soon as possible.

Step 2 Learn About Your Tier 2 Choice

Watch videos to get familiar with your Tier 2 Options.
Hybrid or 401(k)? A Quick Overview provides a quick look.
Hybrid or 401(k)? A Detailed Discussion offers a deeper dive.

Join a live presentation and ask questions.
Get a deeper understanding of your two retirement choices.

Step 3 Learn About Savings Plans and Enroll

Start saving now and boost your retirement.
Invest in URS Savings Plans straight from your paycheck.

Step 4 Schedule a One-on-One Consultation

Retirement Planning Sessions are virtual or in-person.
Still have questions? Talk to a Retirement Planning advisor.

Follow these steps at www.urs.org/us/steps

04/27/23

Medicare Part D Notice

Important Notice About Your Creditable Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 prescription drug plan.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current prescription drug benefits. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription 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 Human Resources for further information.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

HIPAA Non-Discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you of 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. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

Special Enrollment Provisions

Loss of Other Coverage (Except 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 Eligibility Under 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 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.

Other mid-year election changes may be permitted under your plan (refer to "Permitted Midyear Election Changes" section below).

To request special enrollment or obtain more information, contact Human Resources.

Permitted Midyear Election Changes

Due to Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election generally must be irrevocable for the entire plan year (with the exception of HSA benefit elections, for which prospective election changes generally are allowed). As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will generally remain in place until the next open enrollment period, unless you have an approved election change event and certain other conditions are met as outlined in IRS Code Section 125. See your Section 125 premium conversion plan summary plan description (SPD) for further details and a complete listing of permitted change in election events.

Examples of permitted change in election events include:

- Change in legal marital status (e.g., marriage, divorce, annulment, or legal separation)
- Change in number of dependents (e.g., birth, adoption, or death)
- Change in your employment status or your spouse's or covered child's change in employment (e.g., reduction in hours affecting eligibility or change in employment)
- Your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage
- You and/or your spouse or covered child has a change of residence
- Your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment

These are just some examples of permitted mid-year change in election events. Consult with Human Resources for other circumstances that may be permissible mid-year change in election events.

You must notify Human Resources within 30 days of the above change in status, with the exception of the loss of eligibility or enrollment in Medicaid or state health insurance programs - which requires notice within 60 days.

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

How the Health Plan Uses and Discloses Protected Health Information

Under HIPAA, we may use or disclose protected health information (PHI) under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all the ways permitted to use and disclose information will fall within one of the categories. Most of the time we will use, disclose, and request only the minimum information necessary for these purposes.

For treatment. The plan may use or disclose PHI to facilitate medical treatment or services by health providers. The Health Plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

For payment. The plan may use or disclose PHI to make payments to health care providers who are taking care of you. The plan may also use and disclose PHI to determine your eligibility for plan benefits, to evaluate the plan's benefit responsibility, and to coordinate plan coverage with other coverage you may have. For example, the plan may share information with health care providers to determine whether the plan will cover a particular treatment. The plan may also share your PHI with another organization to assist with financial recoveries from responsible third parties

For health care operations. The plan may use and disclose PHI to run the plan. For example, the plan may use PHI in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the plan will not use genetic information for underwriting purposes.

To Business Associates. The plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and disclose protected health information, but only after they agree in writing to safeguard PHI and respect your HIPAA rights. For example, the plan may disclose PHI to a third-party administrator to process claims for plan benefits.

As required by law. We will disclose health information about you when required to do so by federal, state or local law.

To prevent a serious threat to health or safety. The plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To the employer. The plan may disclose PHI to certain employees of the Employer who are involved with plan administration. These employees are permitted to use or disclose PHI only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. PHI cannot be used for employment purposes without your specific authorization.

Workers' compensation. The plan may disclose PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public health. The plan may disclose PHI for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

Health oversight. The plan may disclose PHI to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. The plan may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law enforcement. The plan may disclose PHI if asked to do so by a law-enforcement official in certain limited circumstances.

Family members. The plan may disclose PHI to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the plan, such as availability of plan benefits and information on the processing of any plan benefits (including explanations of benefits (EOBs)).

Coroners, medical examiners, and funeral directors. The plan may disclose PHI to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

National security and intelligence activities. The plan may disclose PHI to authorized federal officials for national security activities authorized by law.

Military. The plan may disclose PHI as required by military and veterans authorities if you are or were a member of the uniformed services.

Research. In very limited situations, the plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

Compliance with HIPAA. The plan is required to disclose PHI to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Authorizations. Other uses or disclosures of PHI not described above will be made only with your written authorization. For example, the plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose PHI for marketing; or to sell PHI. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to PHI about you, subject to certain conditions and exceptions.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting Human Resources. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: (1) Share information with your family, close friends, or others involved in payment for your care. (2) Share information in a disaster relief situation. (3) Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission: (1) Marketing purposes. (2) Sale of your information.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy and security of your PHI.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

More Information

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.
- The plan reserves the right to change the terms of this notice and to make new provisions effective for all PHI that the plan maintains, including PHI created or received prior to any revision. If significant changes are made, the plan will furnish you with a revised copy.

Important Information on How Health Care Reform Impacts Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider. For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Prohibition on Preexisting Condition Exclusions

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A preexisting condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information. Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage? If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Your Employee Rights Under the Family and Medical Leave Act (FMLA)

The FMLA only applies to employers that meet certain criteria. A covered employer is a:

- ***Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year (including a joint employer or successor in interest).***
- ***Public agency (including a local, state, or Federal government agency) regardless of number of employees.***

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

- ***Public or private elementary or secondary school, regardless of number of employees.***

What is FMLA Leave?

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave in a 12-month period to eligible employees for the following reasons:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you
- unable to work,
- To care for your spouse, child or parent with a serious mental or
- physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness may take up to 26 workweeks of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in one block of time. When it is medically necessary or otherwise permitted, you may take FMLA leave intermittently in separate blocks of time, or on a reduced schedule by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is not paid leave, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I Eligible to Take FMLA Leave?

You are an eligible employee if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a covered employer if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management

How Do I Request FMLA Leave?

Generally, to request FMLA leave you must:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You must also inform your employer if FMLA leave was previously taken or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What Does My Employer Need to Do?

If you are eligible for FMLA leave, your employer must:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determines that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where Can I Find More Information?

Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. Scan the QR code to learn about our WHD complaint process.

Your Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

then an employer may not deny you

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment.

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets*. An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

Medicare and Health Savings Accounts (HSAs)

If you are approaching Medicare eligibility and you currently contribute to a Health Savings Account (HSA) that is integrated with a High Deduction Health Plan (HDHP), it is important to understand how HSA eligibility rules and Medicare enrollment interact.

An individual is not eligible to make HSA contributions (nor eligible to have employer contributions made to their HSA) if the individual has other coverage including being enrolled in Medicare. An individual who is enrolled in Medicare is not eligible for continued HSA contributions, however, funds that existed in the HSA prior to Medicare enrollment may continue to be used for ongoing medical expenses.

It is important to be aware that Medicare enrollment based on age or disability cannot be waived by individuals who are receiving Social Security benefits. However, Medicare enrollment may be delayed by delaying the receipt

of Social Security benefits. For those that delay applying for Medicare, enrollment is generally retroactive for up to six months (that is, Medicare coverage will begin up to six months prior to the month in which they applied). Because the first month of Medicare enrollment will be retroactive for individuals who delay applying for Medicare, those individuals should use extra care when determining the amount of their HSA contributions to avoid excess contributions and possible adverse tax consequences.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (or sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059. Also visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Continuation Coverage Rights Under COBRA

Your employer's group health plan may not be subject to COBRA (and this notice will not apply) if your employer had fewer than 20 employees on a typical business day during the preceding calendar year. If your plan is not subject to COBRA, it will be subject to state continuation rights which are similar to COBRA continuation rights.

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[3] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to Human Resources. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[3] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Premiums

Premiums

August 1, 2024 - July 31, 2025

Medical

EMI

$1,500 Traditional Plan - Option 1					
Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35 hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Single	$699.00	$91.00	$168.00	$266.00	$713.00
Two-Party	$1,569.00	$204.00	$377.00	$597.00	$1,600.00
Family	$2,221.00	$288.00	$534.00	$844.00	$2,266.00

$2,000 QHDHP with HSA Plan - Option 2					
Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Employee	$600.00	$21.00	$21.00	$21.00	$612.00
Two-Party	$1,346.00	$46.00	$209.00	$418.00	$1,373.00
Family	$1,907.00	$65.00	$296.00	$591.00	$1,945.00
HSA Employer Contribution of $80 and WCSD will match employee contributions of $20 each month	$80+20(match)= $100	$80+20(match)= $100	$80+20(match) = $100	$80+20(match)= $100	N/A

Dental

EMI

Choice PPO					
Status	Total Premium Per Month	Employer Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Single	$31.00	0.00	$5.00	$9.00	$31.00
Two-Party	$57.00	0.00	$8.00	$16.00	$58.00
Family	$106.00	0.00	$15.00	$30.00	$108.00

Basic Life Plan

Lincoln Financial

Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Employee	2.33	0.00	.30	.59	Portable
Family	.61	0.00	.08	.16	Portable

- **HSA Employer Contribution amount will be pro-rated based on hire date.**

Insurance rate information is estimation only. Employee premiums will be pro-rated based on the fractional amount for certified teachers and based on the hourly amount for classified employees. See District Policy 1200, section 3.2.7.

Meets ACA Affordability Safe Harbor with Minimum Essential Coverage and Minimum Value.

GBS
A Leavitt Group Company