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ESC



Employee Handbook
For Fiscal Department Services 8/24

PAYDATE SCHEDULE 2024-2025 SCHOOL YEAR

Friday, August 16, 2024

Timesheet: July 28 to Aug 10

Friday, August 30, 2024

Timesheet: Aug 11 to Aug 24

Friday, September 13, 2024

Timesheet: Aug 25 to Sept 7

Friday, September 27, 2024

Timesheet: Sept 8 to Sept 21

Friday, October 11, 2024

Timesheet: Sept 22 to Oct 5

Friday, October 25, 2024

Timesheet: Oct 6 to Oct 19

Friday, November 8, 2024

Timesheet: Oct 20 to Nov 2

Friday, November 22, 2024

Timesheet: Nov 3 to Nov 16

Friday, December 6, 2024

Timesheet: Nov 17 to Nov 30

Friday, December 20, 2024

Timesheet: Dec 1 to Dec 14

Friday, January 3, 2025

Timesheet: Dec 15 to Dec 28

Friday, January 17, 2025

Timesheet: Dec 29 to Jan 11

Friday, January 31, 2025

Timesheet: Jan 12 to Jan 25

Friday, February 14, 2025

Timesheet: Jan 26 to Feb 8

Friday, February 28, 2025

Timesheet: Feb 9 to Feb 22

Friday, March 14, 2025

Timesheet: Feb 23 to March 8

Friday, March 28, 2025

Timesheet: March 9 to March 22

Friday, April 11, 2025

Timesheet: March 23 to April 5

Friday, April 25, 2025

Timesheet: April 6 to April 19

Friday, May 9, 2025

Timesheet: April 20 to May 3

Friday, May 23, 2025

Timesheet: May 4 to May 17

Friday, June 6, 2025

Timesheet: May 18 to May 31

Friday, June 20, 2025

Timesheet: June 1 to June 14

Thursday, July 3, 2025

Timesheet: June 15 to June 28

Friday, July 18, 2025

Timesheet: June 29 to July 12

Friday, August 1, 2025

Timesheet: July 13 to July 26

* TIMESHEETS DUE LAST DAY OF PAY PERIOD *

PUTNAM COUNTY EDUCATIONAL SERVICE CENTER

COUNTY BOARD MEMBERS

William F. Goecke, Glandorf
Michael J. Ruhe, Ottawa
Rita M. Schnipke, Ft. Jennings
Frank S. Sukup, Ft. Jennings
Virgil Hohlbein, Ottoville

Michael Siebeneck, Treasurer

DR. JAN L. OSBORN, Superintendent

124 PUTNAM PARKWAY
OTTAWA, OHIO 45875

TELEPHONE (419) 523-5951
FAX (419) 523-6126
www.putnamcountyesc.org

COUNTY SERVICES

General Education Coordination
Special Education Services /
Coordination
Curriculum Services
Preschool & Early Childhood
Education/Coordination
Grants Management
Red Cross Provider
Project MORE
Migrant Education Regional Provider

PUTNAM COUNTY EDUCATIONAL SERVICE CENTER 2024-2025 CALENDAR

The Putnam County Educational Service Center will be closed on the following days.

Labor Day	September 2, 2024
Thanksgiving	November 28 & 29, 2024
Christmas	December 24, 25 & 26, 2024
New Years	December 31, 2024 and January 1, 2025
M. L. King Day	January 20, 2025
Presidents' Day	February 17, 2025
Easter	April 18 & April 21, 2025
Memorial Day	May 26, 2025
Juneteenth	June 19, 2025
Independence Day	July 4, 2025

Board Adopted:

LOCAL SCHOOL DISTRICTS

Columbus Grove - Continental - Jennings - Kalida - Leipsic - Miller City-New Cleveland
Ottawa-Glandorf - Ottoville - Pandora-Gilboa

CALENDAR INFORMATION

If you plan to return on a date other than scheduled, or work other days during the year, the following procedures need to be followed:

1. **PRIOR** approval needs to be granted by the Superintendent.
2. The treasurer's office needs to be notified of this change and approval.
3. The treasurer's office will then update your calendar and return a copy upon your request. The days must be switched in advance; calendars cannot be adjusted with days already paid on your contract.

Teachers don't forget that your "**YEAR-END TEACHER WORK DAY**" is just that. Please don't schedule yourself to do something else on that day unless it is school related. This is the day you use to box things up, etc. Many of you have aides that are required to work both scheduled "teacher work days" (one at the beginning and one at year's end) to fulfill their 186 day contract.

Weekend conferences also need to be cleared with the superintendent, (Travel time to a conference does not count as a day.) A day is a day. **If you normally work 7 hours but have a meeting after school or in the evening it does not constitute a partial day.**

**CALAMITY DAYS AND DELAYS
FOR EMPLOYEES IN LOCAL SCHOOLS:**

Per the negotiated agreement:

Calamity Days

Nothing in this agreement shall require the Board to keep offices and buildings open in the event of inclement weather or when otherwise prevented by an act of God, or an event that causes the closing of schools. When all the schools are closed to students, due to the above conditions, bargaining unit members shall not be required to report to their job assignments and shall suffer no loss of salary. Staff assigned to local buildings will not be required to report to duty when that building is closed due to calamity.

Each school is allowed 5 calamity days per state guidelines. If more days are taken and make-up days are required, you are to report to work for the make-up days.

Delays

In the event of a delay, if the school in which you are scheduled to work has called a delay, report to work according to the local school's procedures. If for some reason you have early arrivals coming to your classroom, contact the service center so arrangements can be made for those students.

FOR NON-TEACHING STAFF ASSIGNED TO ESC

Calamity Days

Calamity days are only honored at the service center office if all 9 local schools have declared it a calamity day. There will be a maximum of 5 calamity days for the service center office.

If the county is on a Level 3, the ESC is closed for the day.

If the county is on a Level 1 or Level 2 road advisory and ALL of our schools are closed, the ESC will remain open with the following stipulations:

- 1) 9 month & 10 month employees should honor the calamity day and stay home
- 2) 12 month employees should report on the calamity day whenever they feel it safe or they do have the option to stay home as long as we are not over the 5 day limit, however, we need to be cognizant of the fact that if none of us come in, the office could not remain open
- 3) There can be a rare exception to this policy, such as if a person is already attending a conference or training on the calamity day. All exceptions must be discussed with the superintendent.

Delays for Office Employees

In the event of a delay of all nine schools and it appears that all schools WILL NOT cancel, then please come in as soon as you feel it safe to travel. A two-hour delay does not mean that you should stay home until the two hours have expired, unless you truly feel it is unsafe to travel until then.

LEAVE

A few notes regarding leave:

SICK LEAVE

Teachers & Aides: When you are off due to illness, you must notify **both** the school and the ESC office. Please input your leave into the AESOP system or call **Absence Management formerly AESOP (1-800-942-3767)** as soon as possible if you need a sub for the day.

All others that do not need subs: When you are off due to illness, please call the ESC office at 523-5951 extension 3003 or enter your leave into KIOSK at your earliest convenience. If you call the office your leave will still need to be entered into the KIOSK system prior to the next payroll.

PERSONAL, PROFESSIONAL, VACATION

When applying for personal, professional, and vacation leave, please submit a request through KIOSK/AESOP so the superintendent has ample time to approve the day(s).

After your entry is recorded the Superintendent approves your request through KIOSK/AESOP and an email is then sent to Donna Hoyt, Assistant Treasurer for payroll purposes and a copy is sent to Nikki Hartman to follow up on the substitute process if needed.

ANNUITY OPTIONS

Listed below are the companies with whom the Putnam County Educational Service Center employees may have annuity deductions taken out of their payroll checks before taxes.

Ohio Public Employees Deferred Compensation Program

Ameriprise Financial Services

American Fidelity Assurance

Aspire Financial Services

If you are interested in any of the above annuity programs or one not mentioned and would like us to make the deduction for you, please contact us. The open enrollment periods are January 1 through March 31 and July 1 through September 30 of each year. Annuity deductions need to be set up on a bi-weekly status (26 per year).

Putnam County ESC

2024 Medical Insurance Plan Design Options

Effective 1/1/2024

1

2

	PPO Plan	High Deductible Health Plan
Deductible	\$1,500 / \$3,000	\$2,500 / \$5,000
Coinsurance Percentage	80 / 20	90 / 10
Coinsurance Limit	\$3,000 / \$6,000	\$1,000 / \$2,000
Maximum Out-of-Pocket	\$4,500 / \$9,000	\$3,500 / \$7,000
Office Visit Copay	\$25	Deductible then Coinsurance
Emergency Room Copay	\$100 then Deductible	Deductible then Coinsurance
Retail Drug Copay	\$15 / \$40 / \$60	Deductible then Coinsurance \$15 / \$40 / \$60
Mail Order Drug Copay	\$30 / \$80 / \$120	Deductible then Coinsurance \$30 / \$80 / \$120
	FSA Compatible 85/15 Split Cost of Premium	H.S.A. Compatible 90/10 Split Cost of Premium Single: HSA Cont = \$1,000.00 Family: HSA Cont = \$2,000.00

New Monthly Employee Share: 2024		
Single:	\$136.10	\$76.14
Family:	\$351.01	\$196.39
New Monthly Employer Share: 2024		Plus H.S.A Semi-Annual Contribution
Single:	\$771.21	\$685.29
Family:	\$1,989.03	\$1,767.48

Current Monthly Employee Share: 2023		
Single:	\$136.10	\$76.14
Family:	\$351.01	\$196.39
Current Monthly Employer Share: 2023		Plus H.S.A Semi-Annual Contribution
Single:	771.21	685.29
Family:	1,989.03	1,767.48

Amount of Employee Monthly change from 2023 to 2024		
Single:	\$0.00	\$0.00
Family:	\$0.00	\$0.00
Amount of Employer Monthly change from 2023 to 2024		Plus H.S.A Semi-Annual Contribution
Single:	\$0.00	\$0.00
Family:	\$0.00	\$0.00

Putnam County Educational Service Center

Bylaws & Policies

3422 - BENEFITS FOR NONREPRESENTED STAFF

Salaries and fringe benefits for all professional staff members not covered by the terms of a currently-valid negotiated, collectively-bargained agreement shall be not less than those provided in the master agreement with the Putnam County Education Association and will be prorated based on a 185 day at seven (7) hours per day contract.

Revised 6/8/09

4421 - GROUP HEALTH INSURANCE

The Board realizes the concern of its employees for the availability of those protective and personally advantageous benefits beyond an individual's basic salary. It is the Board's desire to make available or provide, within the limits of law and sound fiscal management, those which are beneficial to the employee and the District.

The Board shall provide group health insurance for the employees of this District eligible to participate in accordance with statute with the following terms:

Participation in this plan is optional.

For any nonteaching employees initially hired after July 6, 1996, insurance coverage will be as follows:

- A. For employees (who average working thirty (30) hours per week) and are not 12 month employees, the Board will pay 85% of single coverage for PPO plan and 90% of single coverage for High Deductible Plan or fifty percent (50%) of family coverage for medical coverage PPO or High Deductible.
- B. For part-time employees (who average working less than thirty (30) hours per week) the Board will pro-rate coverage based on thirty (30) hours per week.
- C. If an employee works thirty (30) hours or more per week and is a twelve (12) month employee, the Board will pay 85% of coverage PPO plan and 90% of High Deductible Plan for single or family.
- D. If an employee works less than thirty (30) hours per week and is a twelve (12) month employee, the Board will pay 85% of coverage PPO plan and 90% of coverage for High Deductible Plan for single or family. The Board will pro-rate coverage based on standard hours assigned for position.

* The percentage of health insurance to be paid by the employee for the PPO plan may be contributed as part of the American Fidelity 125 Plan.

** For High deductible Option an American Fidelity Health Savings Account may be set up by the employee and the board will contribute \$1,000.00 annually for a single plan and \$2,000.00 annually for a family plan. The Board will pro-rate coverage based on standard hours assigned for position.

R.C. 9.90, 3313.202, 3917.01

Revised 8/1/16

REQUISITION / PURCHASE ORDER SYSTEM

First, before anything is ordered or purchased, you should complete a requisition (each department's secretary can enter this on the computer) and submit for superintendent signature. If the superintendent does not approve the requisition and a PO is not issued before the item is purchased, you may be personally liable for the purchase. After the superintendent approves the requisition, the superintendent gives the form to the assistant treasurer, and the assistant treasurer will process a purchase order from the requisition. The treasurer's office will then email you a copy of the purchase order, at this point you or your department's secretary will be required to place the order, **the treasurer's office will no longer be placing orders**. If there are any other instructions please make special notes on the requisition form.

Please make sure you include **fax number, telephone number, address, email** and **shipping amount**. If there is no shipping, please indicate this on the requisition. Also, if you know % of discount please note amount. If a tax exempt letter is needed, please mark the requisition and it will be sent to the vendor by the treasurer office, include where to send the exemption letter.

For any new vendors, please obtain a W-9 and attach this to the requisition. A purchase order will not be completed until a W-9 is provided for any new vendor.

If a contract is signed (superintendent must sign ALL contracts), make sure a requisition is filled out before the person starts working on the project, or before the contract is signed, whichever is the earliest date.

PUTNAM COUNTY EDUCATIONAL SERVICE CENTER PURCHASE REQUISITION

Requested by: _____

Date: _____

Name of company or person to receive payment:

Ordering/Special Instructions:

Once approved you will receive a purchase order copy from the Treasurer's Office, all purchases will be ordered by Requestor or Department's Secretary.

Telephone No.: _____

Mail Check ☐ Pick up Check ☐
Date Check Needed By _____

Fax No.: _____

Other: _____

Email Address: _____

[illegible]

Approved by:

_____ Date: _____

Program Coord (If Applicable)

_____ Date: _____

Superintendent

Subtotal: _____

Shipping & Handling: _____

Grand Total: _____

Treasurer's Office Use:

Purchase Order Number: _____ Vendor Number _____ Requisition Number: _____

NAME: _____
DEPARTMENT: _____

[illegible]

Date: _____

PUTNAM COUNTY EDUCATIONAL SERVICE CENTER

COUNTY BOARD MEMBERS

Daryl E. Amstutz, Pandora
William F. Goecke, Glandorf
Virgil P. Hohlbain, Ottoville
Lillian L. McKibben, Continental
Marilyn M. Weber, Ottawa

Michael Siebeneck, Treasurer

DR. JAN L. OSBORN, Superintendent

124 PUTNAM PARKWAY

OTTAWA, OHIO 45875

TELEPHONE (419) 523-5951

FAX (419) 523-6126

COUNTY SERVICES

General Education
Coordination
Special Education Services /
Coordination
Preschool & Early Childhood
Education/Coordination
Alternative Education Program
Substance Abuse Prevention
Technology Coordination
Attendance Officer
Grants Management

Overnight Travel Expense Form

Name: _____ Position: _____

Reason for Travel: _____

Maximum Room Allotment: \$125.00 / night (not including occupancy taxes)

Maximum Food Allotment: \$25.00 / day for overnight stay(s) only. Includes meals for the day(s) of the event (not the night prior). An Itemized receipt with the name of the establishment must be presented to the treasurer for reimbursement. We can not reimburse for a tip or alcohol.

- The Hotel Charge Request form must be completed by the Hotel you are requesting for lodging. This is required to obtain the exact cost of room charges. Fill out the top of the form and fax it to the Hotel. (The forms are available in the Administrative Work Area, and on-line)
- When faxing the form to the Hotel, be sure to include an Ohio Blanket Certificate of Tax Exemption so the hotel waives the appropriate taxes for the hotel room. A separate tax exemption form needs to be filled out in addition to the Ohio Blanket Exemption for Columbus area. (The forms are available in the Administrative Work Area, and on-line)
- It is the employee's responsibility to get this information to the Superintendent, with a Requisition, at least two weeks prior to the hotel stay in order to produce a check on time. If not completed properly, expenses over requisitioned/check amount will be the employee's responsibility.

Total Hotel Expense: \$ _____
(From Hotel Charge Request Form)

If accommodations are not available in the area for the amount allotted, prior Superintendent approval is required to exceed policy limits.

Reason Over Maximum Allotment: _____

For Office Use Only

Superintendent's Approval

Superintendent

Date: _____

LOCAL SCHOOL DISTRICTS

Columbus Grove - Continental - Jennings - Kalida - Leipsic - Miller City-New Cleveland
Ottawa-Glandorf - Ottoville - Pandora-Gilboa

PUTNAM COUNTY EDUCATIONAL SERVICE CENTER

COUNTY BOARD MEMBERS

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Michael Siebeneck, Treasurer

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124 PUTNAM PARKWAY

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COUNTY SERVICES

General Education
Coordination
Special Education Services /
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Preschool & Early Childhood
Education/Coordination
Alternative Education Program
Substance Abuse Prevention
Technology Coordination
Attendance Officer
Grants Management

TIN 34-1469588

Hotel Charge Request Form

Hotel Name: _____

Date of Arrival: _____ Date of Departure: _____

Employee Name(s) _____

Meeting Attending: _____

To Whom It May Concern:

The Putnam County Educational Service Center is a non-profit organization (state sub-division) affiliated with the State of Ohio Department of Education. A Blanket Tax Exemption Form is included for your records.

We are sending the above employee(s) from our office to a meeting / seminar and are requesting lodging fees from your Hotel. Please complete the following questions in order for us to have exact charges for the stay. When completed please fax the form to Fax# 419-523-6126.

	Single Occupancy	Double Occupancy
Room charges / night:	_____	_____
State Tax:	<u>Tax Exempt</u>	<u>Tax Exempt</u>
Occupancy/Bed Tax:	_____	_____
Other	_____	_____
Total	_____	_____
Quote Completed By: _____ Title: _____ Date: _____		

The employee will be setting up reservations after appropriate approval is given for the event. After approval, a check will be sent with the employee(s) for the lodging expenses.

Thank you for your help.

LOCAL SCHOOL DISTRICTS

Columbus Grove - Continental - Jennings - Kalida - Leipsic - Miller City-New Cleveland
Ottawa-Glandorf - Ottoville - Pandora-Gilboa



STATE OF OHIO
DEPARTMENT OF TAXATION
SALES AND USE TAX
BLANKET EXEMPTION CERTIFICATE

The purchaser hereby claims exception or exemption on all purchases of tangible personal property and selected services made under this certificate from:

(vendor's name)

and certifies that this claim is based upon the purchaser's proposed use of the items or services, the activity of the purchaser, or both, as shown hereon:

PURCHASER MUST STATE A VALID REASON FOR CLAIMING EXCEPTION OR EXEMPTION.

Purchaser's Name

Street Address

City

State

Zip

Michael Siebensch

Treasurer

Signature and Title

Date Signed

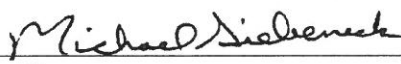
Vendor's License Number, if any

Vendors of motor vehicles, titled watercraft and titled outboard motors may use this certificate to purchase these items under the "resale" exception. Otherwise, purchasers must comply with rule 5703-9-10 of the Administrative Code.

This certificate cannot be used by construction contractors to purchase material for incorporation into real property under an exempt construction contract. Construction contractors must comply with rule 5703-9-14 of the Administrative Code.

Hotel/Motel Excise Tax Exemption Certificate

(To be completed by guest and submitted to registration)

Part A OCCUPANT INFORMATION		
1. Occupant's Name		2. Title
Part B BUSINESS OR INSTITUTION AUTHORIZATION		
1. Name of Business or Institution Claiming Exemption	2. Federal ID No.	3. Telephone No.
Putnam County Educational Service Center	34-1469588	419-523-5951
4. Street Address, City, State and Zip of Business or Institution		
124 Putnam Parkway, Ottawa, OH 45875		
5. Authorized Signature (Treasurer or Financial Officer of Business or Institution):		6. Name (please print):
		Michael Siebeneck
7. Title		8. Date
Treasurer		
Part C HOTEL INFORMATION		
1. Name of Hotel, Apartment Hotel or Lodging House:		2. Arrival Date
		3. Departure Date
4. Hotel Address:	5. Prepared by (Name of Hotel Employee)	6. Hotel Vendors License No.

The person signing this form MUST check the applicable box to claim exemption from the hotel/motel excise tax, imposed by COLUMBUS CITY CODES Chapter 371.2(e) and Tax Regulations of the Franklin County Convention Facilities Authority, Section 2(d). Questions should be directed (preferable in writing) to Hotel/Motel Excise Tax, Division of Income Tax, 50 West Gay Street, 4th Floor, Columbus, OH 43215-9037. Telephone (614) 645-7865.

**STATE AND LOCAL GOVERNMENTS AND POLITICAL SUBDIVISIONS THEREOF**

I certify that the hotel accommodation purchased is to be paid directly with funds from the entity noted on this form and will be used in the exercise of that entity's essential functions. "Directly" does not include per diem, entity advances, or similar indirect payments.

**UNITED STATES GOVERNMENTAL EXEMPTION**

I certify that the hotel accommodation purchased is to be paid directly with funds from the entity noted on this form and will be used in the exercise of that entity's essential functions. Caution: "Directly" does not include per diem, entity advances, or similar indirect payments. Rooms rented to federal government employees who are paying with cash, personal check or personal credit card are subject to tax. This is true even if the employees will be reimbursed by the federal government. Fill in the GSA centrally billed credit card type, prefix and sixth digit:

PLATFORM (Visa and etc.)

PREFIX (First four digits)

SIXTH DIGIT

NOTE TO VENDOR – To be valid this certificate must be filled out completely. Transaction to be reported and exemption claimed at conclusion of guest occupancy. Do not send this certification to the Columbus Income Tax Division. Keep a copy of this certificate for your records since it must be available for audit review


NOTE TO TRANSIENT GUESTS – Parts A & B must be completed prior to and submitted at the time of registration. Legible faxed or scanned exemption certificates received by the vendor from qualifying businesses or institutions will be accepted. Multiple guests from same business or institution may submit one exemption certificate along with schedule detailing individual occupant information in Part A. Do not send this certification to the Columbus Income Tax Division. **KEEP A COPY OF THIS CERTIFICATION FOR YOUR RECORDS.** You are responsible to notify the vendor of cancellation, modification, or limitation of the exemption you have claimed.

**Request for Taxpayer
Identification Number and Certification**

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return) The Putnam County Educational Service Center	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input checked="" type="checkbox"/> Other (see instructions) ▶ State of Ohio Educational Organization	
	Exemptions (see instructions): Exempt payee code (if any) 3 Exemption from FATCA reporting code (if any) _____	
	Address (number, street, and apt. or suite no.) 124 Putnam Parkway City, state, and ZIP code Ottawa, OH 45875 List account number(s) here (optional)	
Requester's name and address (optional)		

Part I Taxpayer Identification Number (TIN) Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3. Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.	Social security number [][]-[][]-[][][][][][] Employer identification number [3][4]-[1][4][6][9][5][8][8]
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------

Part II Certification Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined below), and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3. Sign Here Signature of U.S. person ▶  Date ▶ _____

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.



Asset Transfer Form

Person Requesting Transfer: _____

Asset being transferred from: _____

Asset being transferred to: _____

Asset Tag Number:

Asset Description:

Approved:

Disapproved:

Superintendent Signature:

Date: _____

Please make sure that treasurer receives a copy of this form.



Asset Disposal Form

Person Requesting Disposal: _____

Asset being disposed from: _____

Asset Tag Number:

Asset Description:

If Sold, amount received: _____

Reason for Disposal:

Approved:

Disapproved:

Superintendent Signature:

Date: _____

Please make sure that treasurer receives a copy of this form.

Appendix A

Leave Instructions

Employee
Kiosk



Employee Kiosk Staff Manual

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LOGGING IN

Logging into the Kiosk requires a full email address and user password.



To create a Kiosk Account, click on the First time user link at the login page and the screen on the right will display.

You will be required to enter the following:

1. Either an employee id or social security number
2. Select the county where your district is located
3. Select your district
4. Enter your email address that is on your payroll record. You may need to check with your payroll department to verify the email address on file.

A screenshot of the 'Employee Kiosk' registration page. The header is the same as the login page. The main content area is titled 'To register for the Employee Kiosk, please supply the following:'. Below this, there are four numbered instructions: '1) Your Employee Id or SSN.', '2) The county in which your district resides.', '3) Your district's name.', and '4) Your email address provided to you by your district.' The form fields include: 'Employee Id' (text input), 'OR' (radio button), 'SSN (no dashes)' (text input), 'County' (dropdown menu with 'Select County' selected), 'District' (dropdown menu with 'Select District' selected), and 'Email' (text input). A 'Submit' button is at the bottom left of the form area.

A notification will be sent to the email address you supplied with the password to use for accessing the Kiosk.

Once the password is received you can access the Kiosk using the email address and password. When logging in for the first time you will be prompted to change your password. Currently the Kiosk password does not expire.



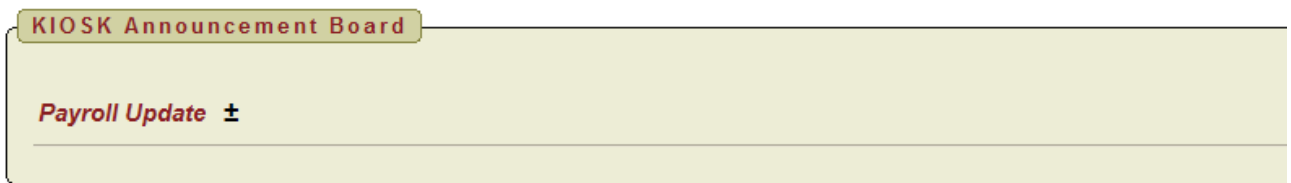
EMPLOYEE KIOSK DOCUMENTATION

This link will take you to the Kiosk website where you can find documentation, see weekly summaries, enhancements suggestions and other information related to the Kiosk software.

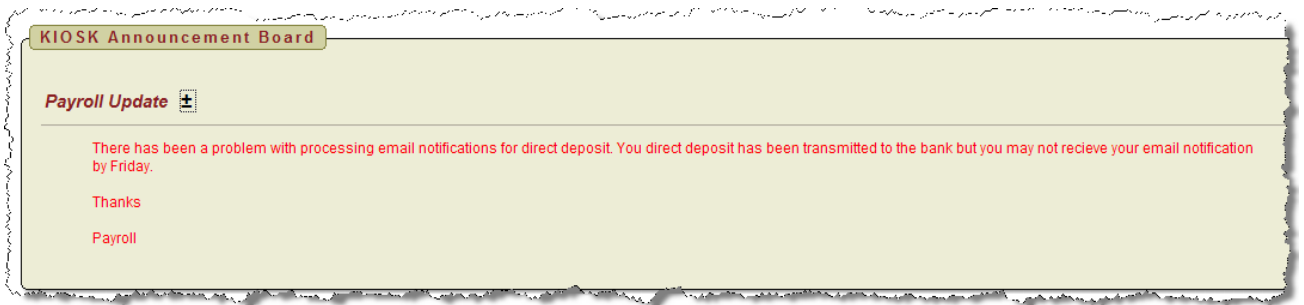


KIOSK ANNOUNCEMENT BOARD

Announcements for staff from administrators will be placed in the Kiosk Announcement Board. To see the full announcement, click (+) symbol next to the announcement title.



Clicking the (-) symbol will close the announcement.



OTHER LINKS

If your district is using the Other Links functionality of the Kiosk you will see links to other websites on your horizontal bar that have been placed there by district administrators. You can click on these links at anytime to go to that website.



PROFILE

The profile page gives the user the personal information drawn from USPS (Uniform School Payroll System).

Employee Profile [Request Profile Data Change\(s\)](#)

Employee ID: GRA000100 State Certification ID:

Name:
First Name: Emily Middle Name: ES Last Name: Teacher Suffix:
Legal First Name: Legal Middle Name: Legal Last Name: Legal Suffix:

Contact Information:
Address 1: 833 Submarine Drive Phone: (444) 444-4444
Street Address 2: District Phone: District Extension:
City: Othertown State: OH Zip Code: 44447
Email Address(es): esteach1@nooc.k12.oh.us, sbaughman@noe.n.com

Other Information:
Gender: Female Ethnicity: Marital Status: Married
OSOE District Code: Sub Days: Spouse's First Name:

Education/Qualifications:
Degree Type: Bachelors ECE Qualification:
Semester Hours: 0 Other Credentials:

Employee Dates:
Date of Birth: 08/09/1955 Last Evaluation: Last Paid: 02/27/2009 Contract Renewal: Limited Contract Exp:
Hire Date: 08/21/2000 Next Evaluation: ODHS New Hire: 08/21/2000

Experience:
Total Years: 0 District: 0.00 Retirement System: 0.00 Ohio Public: 0.00 Non Ohio Public: 0.00 Military: 0.00
Authorized Years: 0 Accredited District: 0.00 Purchased: 0.00 Ohio Private: 0.00 Non Ohio Private: 0.00 Teacher: 0.00
Building: 0.00

If the information is in error you may Request Profile Data changes by clicking on the link in the top right hand corner. You can then enter your change in the white box next to that field that needs the correction and then click Submit Change Request. A request is sent to the payroll staff and they will manually update the payroll system.

The diagram illustrates the process of requesting a profile data change. It shows the **Employee Profile** page with a red arrow pointing from the **Request Profile Data Change(s)** link to a detailed form titled **Request Profile Data Change(s)**. This form contains input fields for all the data shown in the profile page, including Name, Contact Information, Other Information, Education/Qualifications, Employee Dates, and Experience. At the bottom right of the form are **Cancel** and **Submit Change Request** buttons.

POSITION DETAILS

This is a brief view of your contract information.

If you have multiple positions you can select the position from under the Current Positions section and the contract information for that position will display below.

Current Positions

Job Title	Start Date	Job Status	
Elementary School Teacher	09/21/2001	Active	Display Details

[Export to CSV](#)

1 - 1

Position Details

Job Number	1		
Job Title	Elementary School Teacher	Start Date	09/21/2001
Building #00	B1	Job Status	Active
Contract Amount	\$50,000.00	Daily Or Hourly	Daily
Hours in Work Day	7	Pay Per Period	\$1,923.08
Work Days in Contract	183	Calendar Start Date	09/21/2001
Salary Schedule Step	0	Salary Schedule Column	0
Eligible for Sick Leave	Yes		
Eligible for Personal Leave	Yes		
Eligible for Vacation Leave	No		
Supervisor Name	Marcia ES Principal	Supervisor Email	eSPRIN@MCOECN.ORG

PERFORMANCE REVIEWS

If your district is using the functionality of Performance Reviews you will have the ability to see when your last review was done, any documentation that was attached by your supervisor for that review, and when your next review is due.

My Performance Reviews

	Current Evaluation Date	Next Evaluation Date	Documents Attached
VIEW	10/13/1999	-	1

1 - 1

Performance Review Info

Employee Name	Evaluation Date	Next Evaluation Date
SANDRA S BULLOCK	10/13/1999	-

Associated Performance Review Files

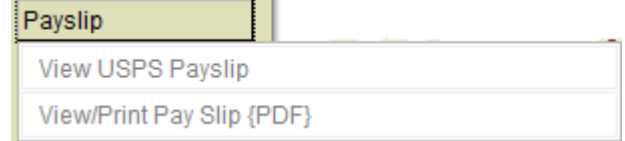
File Id	Filename	Description	Created By	Created Datetime ▲
download	Sandra Bullock 2008 review.docx	Performance Review 2009	KIOSKDEMO@MCOECN.ORG	10/06/2009 04:18 PM

1 - 1

PAYSLIP

There are now 2 options for viewing payslips.



- View USPS Payslip
- View/Print Pay Slip {PDF}

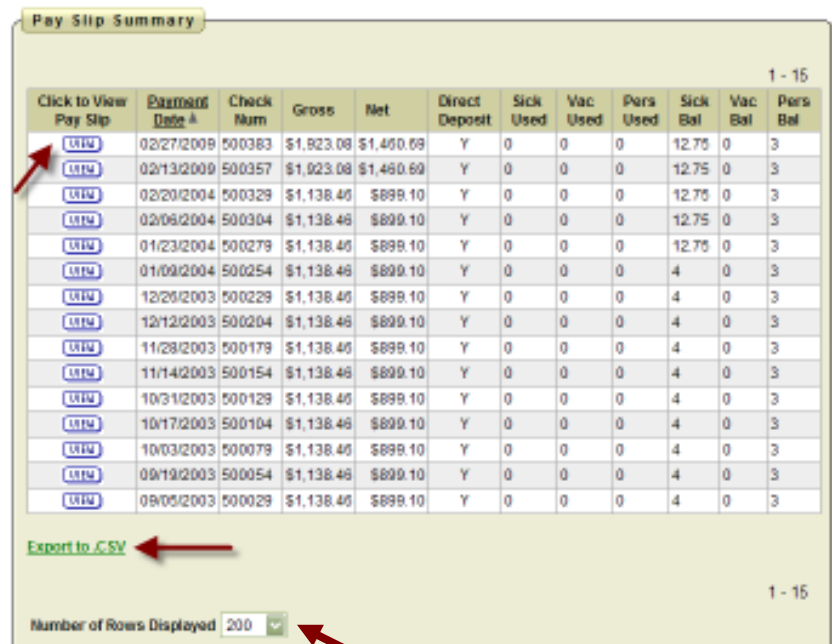


The main difference between the two options is that when you view the USPS Payslip you will not see the year-to-date totals on these payslips. The PDF payslips contain the actual year-to-date totals.

View USPS Payslip

Viewing USPS Payslip permits the user to view past pay slips.

1. When you first select the USPS Payslip option you are prompted with a starting and ending date.
2. The default is the last 3 months of pay.
3. You can click on the calendar icon to change the date range.
4. Once you have your date range entered you can click Load Payslips.
5. You then are presented with a list of payslips. Click view icon to see the payslip detail.
6. The data may be exported to a .csv file (spreadsheet), not requiring you to contact payroll to get this information.
7. The number of payslips that are displayed can be changed by selecting the drop down arrow and setting the display to another number.



Click to View Pay Slip	Payment Date	Check Num	Gross	Net	Direct Deposit	Sick Used	Vac Used	Pers Used	Sick Bal	Vac Bal	Pers Bal
VIEW	02/27/2009	500383	\$1,823.08	\$1,460.69	Y	0	0	0	12.75	0	3
VIEW	02/13/2009	500357	\$1,823.08	\$1,460.69	Y	0	0	0	12.75	0	3
VIEW	02/20/2004	500329	\$1,138.46	\$899.10	Y	0	0	0	12.75	0	3
VIEW	02/06/2004	500304	\$1,138.46	\$899.10	Y	0	0	0	12.75	0	3
VIEW	01/23/2004	500279	\$1,138.46	\$899.10	Y	0	0	0	12.75	0	3
VIEW	01/09/2004	500254	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	12/26/2003	500229	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	12/12/2003	500204	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	11/28/2003	500179	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	11/14/2003	500154	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	10/31/2003	500129	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	10/17/2003	500104	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	10/03/2003	500079	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	09/19/2003	500054	\$1,138.46	\$899.10	Y	0	0	0	4	0	3
VIEW	09/05/2003	500029	\$1,138.46	\$899.10	Y	0	0	0	4	0	3

The information displayed is the same as that on the direct deposit email notification.

View / Print Pay Slip

*** NOTIFICATION OF DEPOSIT ***

PRINT Pay Slip

To: Emily E. Decker
 FROM: DEUCE TEST BANK
 1234 DECKMAN BLVD
 WASHINGTON DC 20005

The accounts designated in your Authorization Agreement for automatic deposits are credited in the amount of \$1,400.00

Funds are available in your account(s) as of 01/27/2008

Your salary has been deposited as follows:

TYPE	DESCRIPTION	AMOUNT
Checking	Direct Deposit - 750	\$1,400.00

Below is a summary of your pay for the period ending 01/27/2008

PAY			DEDUCTIONS		
DATE	DEBIT	CREDIT	DATE	DEBIT	CREDIT
01/27/08	10,000	2,741.31	FED	141.71	971.88
01/27/08	10,000	2,741.31	STATE	141.31	971.88
01/27/08	10,000	2,741.31	CITY	141.31	971.88
01/27/08	10,000	2,741.31	UNEMP	141.31	971.88
01/27/08	10,000	2,741.31	RETIRE	141.31	971.88
01/27/08	10,000	2,741.31	HEALTH	141.31	971.88
01/27/08	10,000	2,741.31	WELFARE	141.31	971.88
01/27/08	10,000	2,741.31	OTHER	141.31	971.88
01/27/08	10,000	2,741.31	TOTAL	1,414.24	9,586.69

Gross Salary: 1,400.00
 Adjusted Gross: 1,791.71
 **GROSS T-2-S: 1,400.00

* Deductions: 1,414.24

** 100% TO DATE TOTALS SHOWN ON THIS DOCUMENT ARE AS OF 01/27/2008

Sick Leave	Vacation Leave	Personal Leave	Service Days
0.000 / 0.000	0.000 / 0.000	0.000 / 0.000	12 / 12

TOTAL EARNINGS: 1,791.71
 Total Deductions: 1,414.24
 Net Pay: 377.47

View/Print Pay Slip {PDF}

- When you first select the View/Print Pay Slip {PDF} option you can
 - View and/or Print Payslip
 - Download & Save Payslip

List of Available Payslips

1 - 1

View and/or Print Payslip	Download & Save Payslip	Pay Date	Check Number
		01282011	588680

1 - 1

- View and/or Print will open your payslip as a PDF file.
- Download & Save will give you the option to save the pay slip to your PC.

Note: The PDF payslip will include year-to-date totals.

VIEW/PRINT W-2

If your district is using the W2 functionality within Kiosk you will see your W2 information that can be viewed or printed.



KIOSK.EMPLOY

[Employee Kiosk](#)

[Other Links](#)

[IPDP](#)

[Scheduler](#)

- Employee Kiosk Documentation
- Profile
- Position Details
- Performance Reviews
- Payslip
- View/Print W-2
- Leave Balances
- Leave Request
- Substitute Coordinator Leave Reports
- View Building Leave Calendar(s)
- Change Password

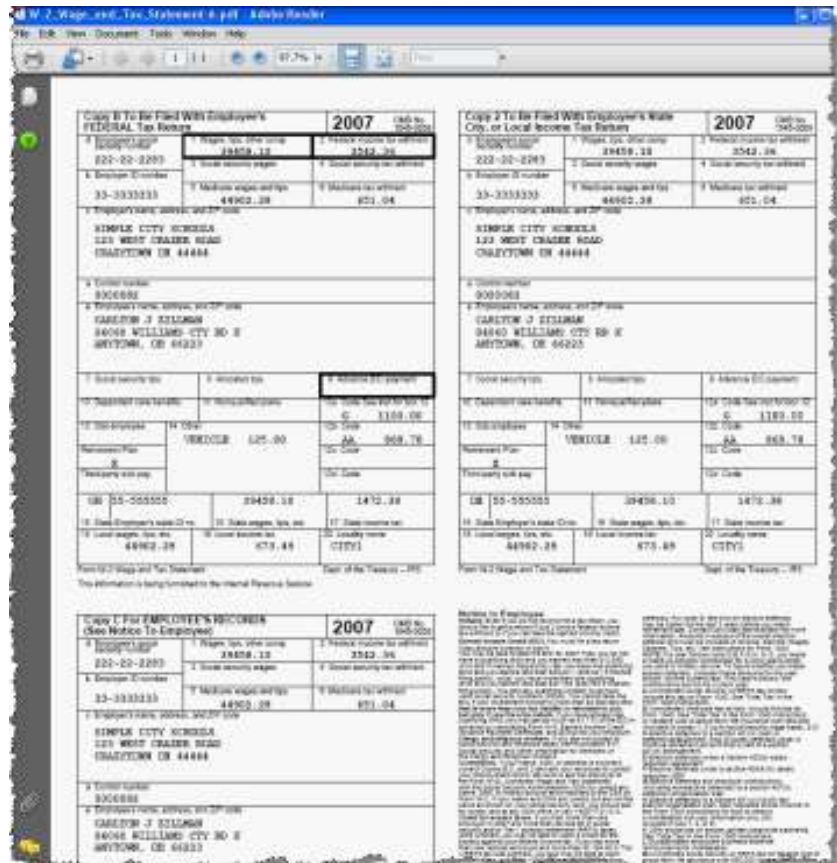
List of Available W-2 Wage and Tax Statements

1 - 1

View and/or Print W2	Download & Save W2	Tax Year	Control Number
		2007	

1 - 1

The tax years that are available will display on the screen. When you click on View and/or Print for a specific W2 your W2 will display on the screen as a PDF.



The screenshot shows a PDF document titled "W-2 Wage and Tax Statement 2007". It contains two identical copies of a W-2 form for the year 2007. The employee is CARLETON J STELMAN, 84048 WILLIAM CTY RD E, ANYTOWN, OH 44623. The employer is SIMPLE CITY KIOSK, 123 WEST CHASE ROAD, CHASESTOWN OH 44114. The form includes fields for wages, taxes, and other information. The document is displayed in a browser window with a toolbar at the top.

LEAVE BALANCES

At this screen the user can see the types of leave they have and a quick balance of each. This balance reflects just the leave requests that have been exported into USPS.

Leave Balances					
	Monthly Accrual	Unit	Accum Max	Begin Bal	Balance
Personal Leave	N/A	Daily	3.00	3.00	3.00
Sick Leave	1.25	Daily	200.00	N/A	12.75
Vacation Leave	0.00	Daily	0.00	N/A	0.00
1 - 3					
NOTICE: Displayed Leave Balances may not reflect current activity due to delayed posting.					

You can also see detailed information of absences and accumulations for available leave types. You can filter the information to only display information based on Category (Leave Types which could include sick, personal, vacation, etc.), Job Number, Transaction Type (Either Absence or Accumulation), and Start/End Date. Once you have selected how you want the information filtered you must press the Go icon to initiate your filter.

Each column that is underlined gives you the ability to sort the information based on that column. To sort on Activity Date so that the most recent dates are at the top click on the Activity Date.

Filter Detail Leave Activity					
Category	JobNo	TransType	Start Date	End Date	
All	All	All			Go

Detail Leave Activity					
Number of Rows Displayed 100					
<u>Category</u>	<u>Job No.</u>	<u>Trans Type</u>	<u>Length Of Absence</u>	<u>Unit</u>	<u>Activity Date</u>
Sick	0	Accumulation	1.25	Daily	02/01/2004
Sick	0	Accumulation	1.25	Daily	01/01/2004
Sick	0	Accumulation	1.25	Daily	12/01/2003
Sick	0	Accumulation	1.25	Daily	11/01/2003
Sick	0	Accumulation	1.25	Daily	10/01/2003
Sick	0	Accumulation	1.25	Daily	09/01/2003
Sick	0	Accumulation	1.25	Daily	08/01/2003
Personal	0	Accumulation	3	Daily	07/01/2003
Sick	0	Accumulation	4	Daily	07/01/2003

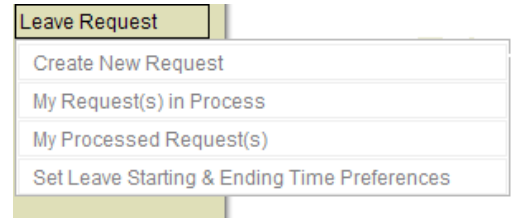
[Export detail activity to CSV](#)

1 - 9

LEAVE REQUEST

There are 4 areas under Leave Request:

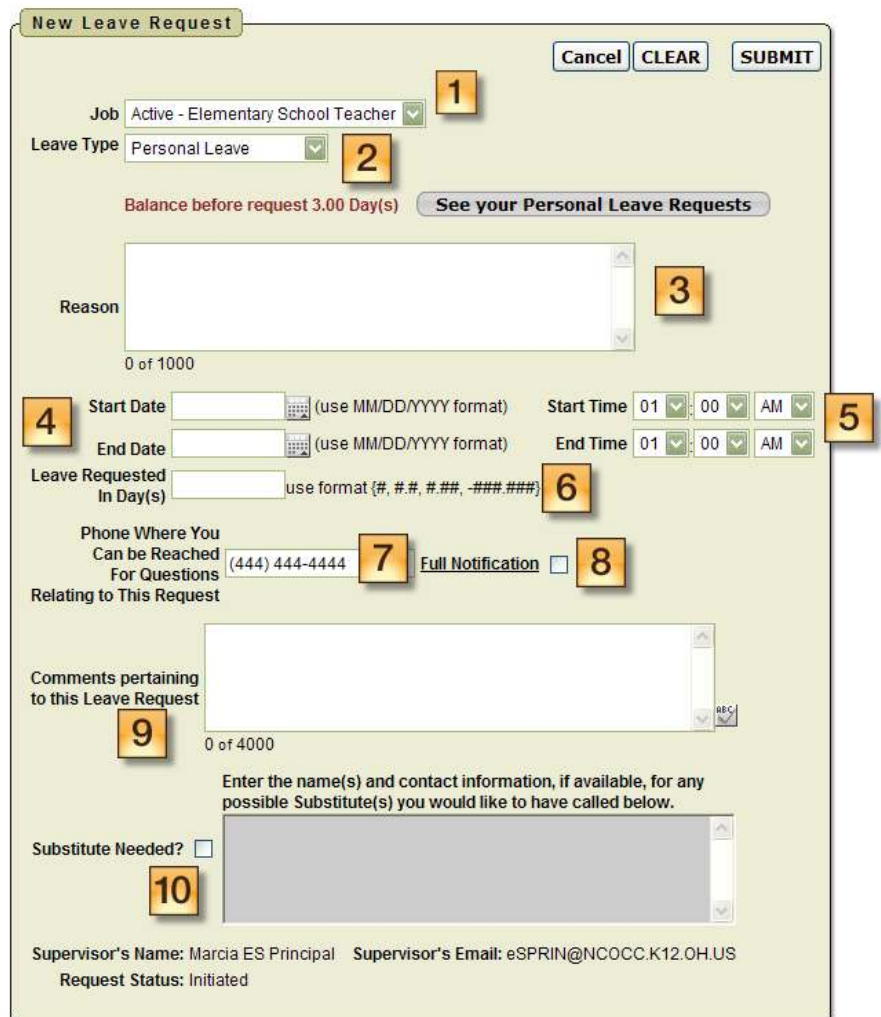
- ☐ Create New Request
- ☐ My Request(s) in Process
- ☐ My Processed Request(s)
- ☐ Set Leave Starting & Ending Time Preferences



Leave Request
Create New Request
My Request(s) in Process
My Processed Request(s)
Set Leave Starting & Ending Time Preferences

Create New Leave Request.

1. Make sure your job that is eligible for leave is selected.
2. Select your leave type. If your district requires an additional reason for a specific leave type (sub-category) another box will display to select additional reasons for the leave request. Once you have selected your leave type a balance of that leave type will display and you will have an icon to click on to see additional leave requests that have been requested but not subtracted from the balance for that leave type.



New Leave Request

Cancel CLEAR SUBMIT

Job: Active - Elementary School Teacher **1**

Leave Type: Personal Leave **2**

Balance before request 3.00 Day(s) [See your Personal Leave Requests](#)

Reason **3**

0 of 1000

4 Start Date (use MM/DD/YYYY format) **5** Start Time 01:00 AM

6 End Date (use MM/DD/YYYY format) **5** End Time 01:00 AM

Leave Requested In Day(s) **6** use format {#, ##, ###, ###, ###}

Phone Where You Can be Reached For Questions Relating to This Request (444) 444-4444 **7** Full Notification ☐ **8**

Comments pertaining to this Leave Request **9**

0 of 4000

Enter the name(s) and contact information, if available, for any possible Substitute(s) you would like to have called below.

Substitute Needed? ☐ **10**

Supervisor's Name: Marcia ES Principal Supervisor's Email: eSPRIN@NCOCC.K12.OH.US

Request Status: Initiated

3. You will need to enter a reason for the request. Some districts require a reason for specific leave types. If your district requires a reason you will receive an error if you leave the field blank.
4. Start and End Date are both required – if you forget the date, you will be prompted to add it upon a submitting your request. You can click on the calendar icon to display a calendar to use to select your date.

5. Start and End Times are both required – if you forget the time, you will be prompted to add it upon submitting your request. This can be set as a preference. See Set Leave Starting & Ending Time Preferences section.

6. Enter amount of time you are requesting off. If your district uses hours you will enter your time in hours. If your district uses days you will enter your request in increments of .25.

7. Your phone number will be populated from your Profile information.

8. Place a check mark in the box if you want to receive an email every time action is taken on your request. If you do not place a check mark in this box you will receive an email message when the request is initiated and when it has received final approval.

The screenshot shows the 'New Leave Request' form. At the top right are buttons for 'Cancel', 'CLEAR', and 'SUBMIT'. The form fields are as follows: 'Job' is a dropdown menu showing 'Active - Elementary School Teacher' (callout 1); 'Leave Type' is a dropdown menu showing 'Personal Leave' (callout 2); 'Balance before request 3.00 Day(s)' is displayed next to a button 'See your Personal Leave Requests'; 'Reason' is a large text area (callout 3); 'Start Date' and 'End Date' are date pickers with instructions '(use MM/DD/YYYY format)' (callout 4); 'Start Time' and 'End Time' are time pickers showing '01:00 AM' (callout 5); 'Leave Requested In Day(s)' is a text field with instructions 'use format (#, ##, ###, ####, #####)' (callout 6); 'Phone Where You Can Be Reached For Questions' is a text field showing '(444) 444-4444' (callout 7); 'Full Notification' is a checkbox (callout 8); 'Comments pertaining to this Leave Request' is a large text area (callout 9); 'Substitute Needed?' is a checkbox (callout 10); and at the bottom, 'Supervisor's Name: Marcia ES Principal' and 'Supervisor's Email: eSPRIN@NCOCC.K12.OH.US' are displayed, along with 'Request Status: Initiated'.

9. Enter any comments you want your supervisor to be aware of.

10. If you need a substitute you will need to check the box and then the comment box will be available for you to type a comment in. This information will then be displayed to anyone who has access to view your request.

NOTE: Some districts may have configured Substitute Needed box to already be checked for you when you create a request. If the box is checked to show you need a substitute then you will be able to click in the comment box to type your comment for this request.

11. You have the ability to attach a document to your leave request. You may need to attach a doctor's excuse, an agenda or registration form for a meeting. Click on Select File(s) to attach.

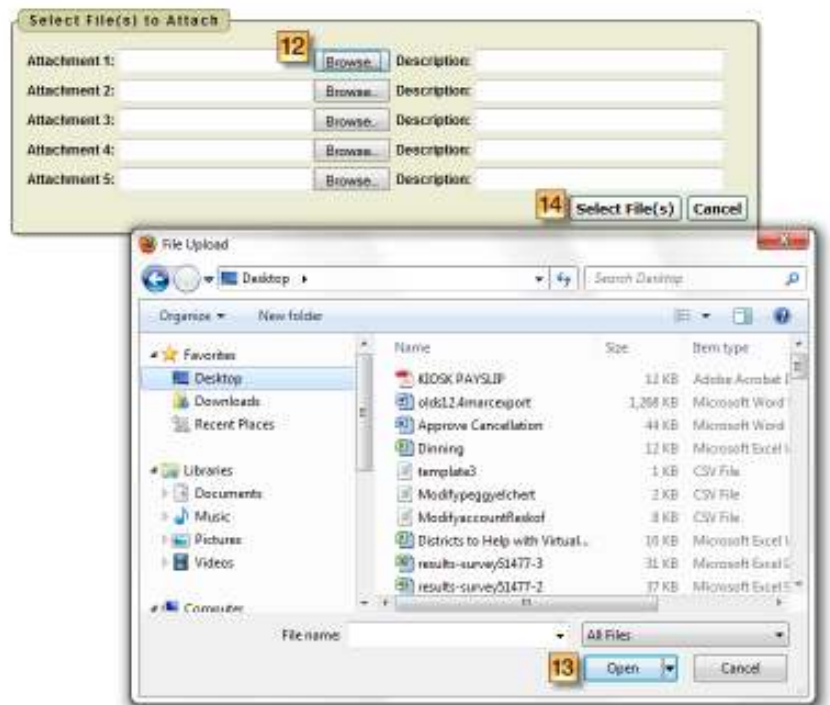
The screenshot shows the 'File(s) to Attach' section. It includes a button 'Click button below to select file(s) to be attached to this Leave Request.' (callout 11) and a button 'Select File(s) to Attach'.

12. Click browse to find the attachment that is located on your PC.

13. Once you have located the file click open.

14. Type in a description for your file and click Select File(s).

15. When your request has been filled out completely press the submit button.



If you choose Professional Leave from the drop down menu, another form appears with the needed information for a professional leave.

1. You can enter the location of the event.

2. If your district requires you to enter the vendor information in the instance when a purchase order needs to be made out to the vendor.

3. Enter any information that you want about the request. For example who the purchase order should be made out to for registration or if you are sharing expenses with a co-worker.

4. Enter your expenses. Enter the miles of the proposed trip and the tool will calculate the mileage amount to be reimbursed based on the district entered rate.

- At the bottom of the Professional Leave Form Part, you may click on Calculate to have it total the expenses entered. *(The fields appearing are set by the administrator, and some features can be added, for instance, the fund code could be added.)*

- Once you have submitted the request for professional leave you have the ability to print a Professional Leave Request Form to submit after your leave so you can enter your actual expenses, attach receipts and submit for reimbursement.

Professional Leave Request Form

Name: Emily Es Teacher Today's Date: 11/23/2009
Position: Elementary School Teacher

Start Date: November 30, 2009 Time: 09:00 AM
End Date: November 30, 2009 Time: 03:00 AM

Total Leave requested: 1 Day(s)

Reason from Leave Request: Meeting

Location of Meeting: Professional Leave Event: Columbus, OH 43224

Purpose of Meeting: Meeting

Vendor Location: ODE Columbus, OH 43221

		EXPENSES	
		Estimated	Actual
Travel:	150 miles @0.400 per mile:	\$60.00	
	Lodging Amount:	\$0.00	
	Meals Amount:	\$15.00	
	Registration Fees:	\$50.00	
	Other Expenses Amount:	\$10.00	
	Total Expenses Amount:	\$135.00	

** PAID RECEIPTS MUST BE ATTACHED FOR ALL EXPENSES **

If you submit a request that will span multiple days you will then be presented a screen to verify the dates and the leave request for each day.

Leave Request Information

Start Date	Start Time	End Date	End Time	Total Leave Day(s)
12/07/2009	07:30 AM	12/11/2009	03:00 PM	5

[Verify Leave Detail Day\(s\) and Click ACCEPT LEAVE DETAILS button to ADD the request.](#)

Week One

Sunday , December 06, 2009	Monday , December 07, 2009	Tuesday , December 08, 2009	Wednesday, December 09, 2009	Thursday , December 10, 2009	Friday , December 11, 2009	Saturday , December 12, 2009
0	1	1	1	1	1	0

Accept Leave Details **Cancel**

My Request(s) in Process

You can quickly see all requests, what their status is, and where they fall in the steps toward approval.

Leave Request(s) in Process										1 - 1
	Update	View Approval Status		Job Description	Leave Type Requested	Status	Substitute Needed	Last Activity Date	Start Date	End Date
Details	Update		-	Elementary Principal	Sick Leave	Flow Initiated Level 1	Yes	02/03/2011 03:38PM	01/27/2011 07:00AM	01/27/2011 04:00PM
Export to CSV										1 - 1
Number of Rows Displayed: 5										

You can click on the word 'Details' to see the original request.

You will see a non-edit-able view of your original request and can do the following when looking at the details of the request.

1. Escalate (this will send a notification to the HR Admin)
2. Cancel the Request
3. Make Comments
4. Add Attachment
5. Update Request. As long as the first approver has not taken action on your request you have the ability to click update request and make changes to your request and then click the apply changes button. Once a request has had action taken on the request you will not be able to update it.

Leave Request Detail

1 Escalate to HR Leave Administrator

Cancel Request

2

3 Apply Comments ONLY

Status: Flow Initiated

Last Activity: 02/03/2011 03:39 PM

Job: Elementary Principal

Leave Type: Sick Leave

Current Balance 39.75 Day(s)

Reason:

Start Date: 01/27/2011 Start Time: 07:00 AM

End Date: 01/27/2011 End Time: 04:00 PM

Leave Requested in Day(s): 1.000

Phone: (111) 111-1111

Full Notification: N

Comments:

5 Update Request

Transaction History

Name	Action	Comments	Transaction Date
Nadia ES Principal	Flow Initiated	-	02/03/2011 03:39PM
Nadia ES Principal	Substitute Needed	-	02/03/2011 03:39PM

[Export to CSV](#)

1 - 2

Number of Rows Displayed: 5

File(s) to Attach

Click button below to select file(s) to be attached to this Leave Request.

Select File(s) 4

Further to the right you will see the approval process.

When you click on the Update from the My Leave Request(s) in Process screen you have the ability to click update request and make changes to your request and then click the apply changes button. Once a request has had action taken on the request you will not be able to update it.

Leave Request(s) in Process

1 - 1

	Update	View Approval Status		Job Description	Leave Type Requested	Status	Substitute Needed	Last Activity Date	Start Date	End Date
Details	Update		-	Elementary Principal	Sick Leave	Flow Initiated Level 1	Yes	02/03/2011 03:38PM	01/27/2011 07:00AM	01/27/2011 04:00PM

[Export to CSV](#)

1 - 1

Number of Rows Displayed: 5

Update Leave Request

[Return to Leave Request\(s\) in Process](#)
[Apply Changes](#)

Initiated: 02/03/2011 03:39 PM

Job: Active - Elementary Principal

Leave Type: Sick Leave

Balance before request 39.75 Day(s)

Flu


Reason

3 of 1000

Start Date: 01/27/2011 (use MM/DD/YYYY format) Start Time: 07 : 00 : AM

End Date: 01/27/2011 (use MM/DD/YYYY format) End Time: 04 : 00 : PM

Leave Requested in Day(s): 1.000 (use format (N, N.A, N.NN, -NNN.NNN))

When you click on the  icon from the My Leave Request(s) in Process screen you will see the approval tree and where the request lies in that tree. The tree is set up by the admin.





My Processed Request(s)


This report reflects those leaves that have been completely processed and are probably in the past. These requests would include those that have been approved and exported to USPS or those requests that have been rejected or cancelled.

- You can filter these requests based on
- Start/End Date
- Leave Type
- Status

Filtering on any of the areas above requires you to click the GO icon to initiate the filter.

Filter by Date Range

Starting Date  Ending Date 

Leave Type Status 


The sections are divided by Approved and Exported Leave Requests and Cancelled and Rejected Leave Requests

In the Approved and Exported Leave Requests section

Approved & Exported Leave Request(s)										
row(s) 1 - 5 of 19										
	View Approval Status	Job Description	Leave Type Requested	Status	Substitute Needed	Last Activity Date	Start Date	End Date	Total Leave	Create Cancellation
Details		- Elementary School Teacher	Sick Leave	Exported	Yes	08/31/2010 03:33PM	07/07/2010 07:00AM	07/07/2010 03:00PM	7.000 Hour(s)	
Details		- Elementary School Teacher	Sick Leave	Exported	Yes	08/31/2010 03:33PM	05/19/2010 07:00AM	05/19/2010 03:00PM	8.000 Hour(s)	
Details		- Elementary School Teacher	Compensatory Time	Approved	No	08/13/2010 03:31PM	08/13/2010 03:00PM	08/13/2010 05:00PM	2.000 Hour(s)	-
Details		- Elementary School Teacher	Compensatory Time	Approved	No	08/13/2010 03:31PM	08/23/2010 03:00PM	08/23/2010 06:00PM	3.000 Hour(s)	-
Details		- Elementary School Teacher	Sick Leave	Approved	Scheduled	08/21/2010 12:44AM	08/20/2010 07:00AM	08/21/2010 03:00PM	16.000 Hour(s)	-
Export to CSV										
row(s) 1 - 5 of 19										
Number of Rows Displayed: 5										
										
 PRINT Filtered Requests										

You can click on the word 'Details' to see the original request.

You will see a non-edit-able view of their original request and further to the right you will see the transaction history for this request.

When you click on the  icon from the My Leave Request(s) in Process screen you will see the approval tree and where the request lies in that tree. The tree is set up by the admin.

You will also see a column with the status of leave request. Exported are requests that have been exported into payroll. Approved requests have been through the approval process but have not been exported to payroll.

If your request has the status of Exported you have the option to cancel the request by clicking on the red X in the Create Cancellation column.

Approved & Exported Leave Request(s)										
										row(s) 1 - 5 of 19
	View Approval Status	Job Description	Leave Type Requested	Status	Substitute Needed	Last Activity Date	Start Date	End Date	Total Leave	Create Cancellation
Details		- Elementary School Teacher	Sick Leave	Exported	Yes	08/31/2010 03:33PM	07/07/2010 07:00AM	07/07/2010 03:00PM	7.000 Hours	
Details		- Elementary School Teacher	Sick Leave	Exported	Yes	08/31/2010 03:33PM	05/19/2010 07:00AM	05/19/2010 03:00PM	8.000 Hours	

When you click the red X a leave request will be created and automatically populated with the correct information for the leave cancellation. You can enter comments in the request as to why the request is being cancelled.

Click Submit to create the cancellation request and send it through the approval process.

New Leave Request

Cancel

SUBMIT

Job Active - Elementary School Teacher

Leave Type Sick Leave

Balance before request 12.75 Hour(s)

See your Sick Leave Requests

Reason

Negative request to reverse/cancel leave time previously Expoted and Posted to USPS. Original Leave Request#1211028

116 of 1000

Start Date 07/07/2010

Start Time 07:00 AM

End Date 07/07/2010

End Time 03:00 PM

Leave Requested In Hour(s)

-

7

000

Phone Where You Can be Reached For Questions

(444) 444-4444

Full Notification ☐

Relating To This Request

Comments pertaining to this Leave Request

0 of 4000

Supervisor's Name: Narda ES Principal

Supervisor's Email: esprin@cncoc.k12.oh.us

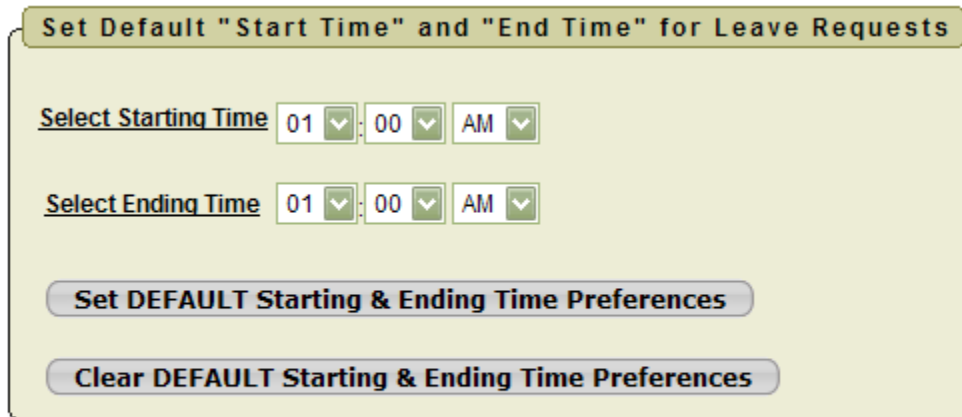
Request Status: Initiated

You may choose how many rows to view by clicking on the drop down arrow next to Number of Rows Displayed.

Approved & Exported Leave Request(s)					
	View Approval Status		Job Description	Leave Type Requested	Status
Details		-	Elementary School Teacher	Sick Leave	Exported
Details		-	Elementary School Teacher	Sick Leave	Exported
Details		-	Elementary School Teacher	Compensatory Time	Approved
Details		-	Elementary School Teacher	Compensatory Time	Approved
Details		-	Elementary School Teacher	Sick Leave	Approved

Set Leave Starting & Ending Time Preference

You can enter a starting and ending time preference so that when you go to create a leave request the starting and ending time that you have set as a preference will be automatically entered into the leave request when creating a new request.



The screenshot shows a dialog box titled "Set Default 'Start Time' and 'End Time' for Leave Requests". It contains two time selection fields. The first field is labeled "Select Starting Time" and shows "01" for the hour, "00" for the minute, and "AM" for the period. The second field is labeled "Select Ending Time" and also shows "01" for the hour, "00" for the minute, and "AM" for the period. Below these fields are two buttons: "Set DEFAULT Starting & Ending Time Preferences" and "Clear DEFAULT Starting & Ending Time Preferences".

1. Enter a starting time
2. Enter a ending time
3. Click Set Default Starting & Ending Time Preferences

CHANGE PASSWORD

This feature will allow you to change your password once you are logged into Kiosk.

You must enter your old password and then type the new one twice before clicking on 'Change Password'.

Your password must be 8 characters in length.

Your district has the ability to configure that your password change in a certain number days. Your district may also require you to use at least one capital letter, number or special character when creating your password. They will let you know of those requirements.



The screenshot shows a "CHANGE PASSWORD" form. It has three input fields: "Old Password", "New Password", and "Re-Enter New Password". The "New Password" field has a note next to it that says "(must be at least 8 characters)". Below the input fields is a blue text prompt that says "Please enter old and new passwords.". To the right of the input fields are two buttons: "Change Password" and "Cancel".

CORRESPONDENCE

This feature will allow you to send messages to the Kiosk Admin from within the Kiosk software.



When you click on Contact Kiosk Admin a message box will display for you to type a message that will be sent to the Kiosk Admin for your district. Click Send with done typing your message.

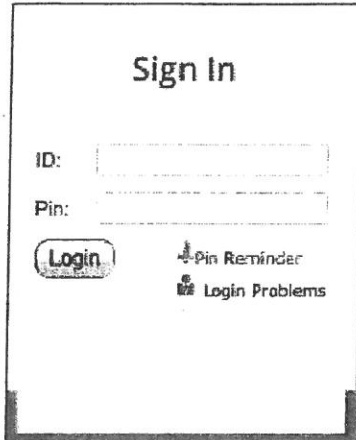
When you click on Correspondence you will see a list of the message you have sent.

Opened	Subject	Status	Last Message
02/07/2011 02:33:27PM	Sick Leave Accrual	Pending	My sick leave accrual amount does not look correct.

To view the correspondence between you and the Kiosk Admin click on the magnifying glass. You will see a history of the correspondence and have the ability to send a new message.

Date	From	Message
02/07/2011 02:33:27PM	PAYROLL@NCODCC.K12.OH.US	I will double check with the signed contract but I think it is correct.
02/07/2011 02:33:27PM	ESPRIN@NCODCC.K12.OH.US	My sick leave accrual amount does not look correct.

Absence and Substitute Management



Sign In

ID:

Pin:

Login [Pin Reminder](#) [Login Problems](#)

LOGGING IN ON THE WEB

To log in to the absence management system, type aesoponline.com in your web browser's address bar.

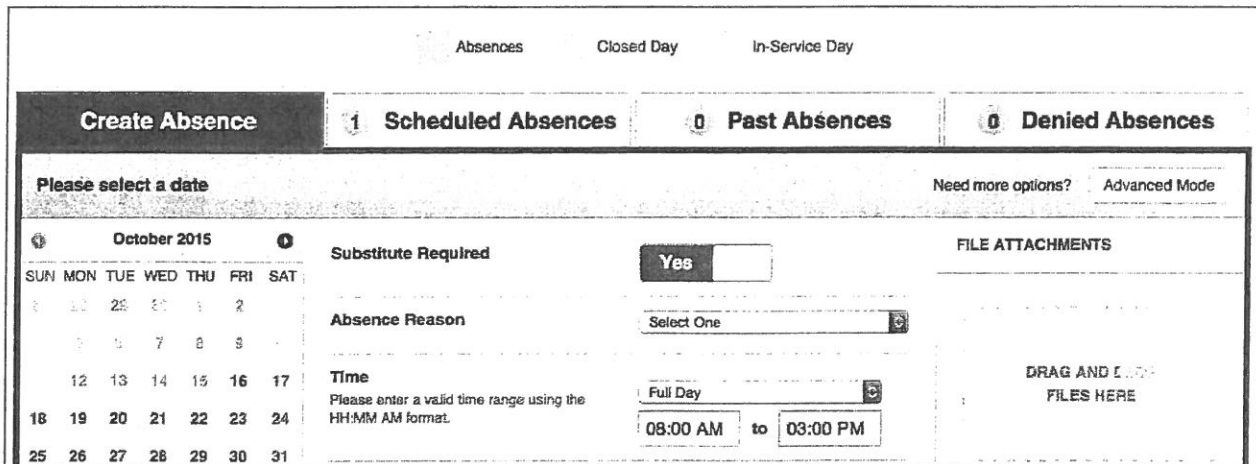
The Sign In page will appear. Enter your ID and PIN and click **Login**.

CAN'T REMEMBER YOUR LOGIN INFO?

If you're having trouble logging in, click the **Login Problems** link next to the "Login button for more information.

CREATING AN ABSENCE

You can enter a new absence from your absence management home page under the **Create Absence** tab.



Absences **Closed Day** **In-Service Day**

Create Absence **1 Scheduled Absences** **0 Past Absences** **0 Denied Absences**

Please select a date Need more options? **Advanced Mode**

October 2015

SUN	MON	TUE	WED	THU	FRI	SAT
		25	26	27	28	29
		1	2	3	4	5
		6	7	8	9	10
	11	12	13	14	15	16
	17	18	19	20	21	22
	23	24	25	26	27	28
	29	30	31			

Substitute Required **Yes**

Absence Reason **Select One**

Time **Full Day**

Please enter a valid time range using the HH-MM AM format.

08:00 AM to **03:00 PM**

FILE ATTACHMENTS

DRAG AND DROP FILES HERE

Fill out the absence details including the date of the absence, the absence reason, notes to the Administrator or substitute, and more. You can also attach files to the absence from here.



✓ Create Absence

When you're completed entering the absence details, click the **Create Absence** button.

MANAGING YOUR PIN AND PERSONAL INFORMATION

Personal Info	Personal Info
Change Phone Pin	General Information
Shared Attachments	Name: Bob Barker
Preferred Substitutes	Phone: 9125555670
Excluded Substitutes	Email Address: bobarker@loaming.ed
Absence Reason Balances	Title:
	Room Number: Main Office
	Language: English Your language preference can be changed in your Account Settings.

Using the “Account” option, you can manage your personal information, change your PIN number, upload shared attachments (lesson plans, classroom rules, etc.), view absence reason balances, manage your preferred substitutes, and more.

GETTING HELP AND TRAINING

If you have questions, want to learn more about a certain feature, or need more information about a specific topic, click **Help Resources** and select **Frontline Support** to go to the absence management Learning Center, where you can search a knowledge base of help and training materials.

HELP RESOURCES	
CONTACT YOUR ORGANIZATION	
Victoria County School District	
Eric Owens	PHI SAT
Phone: (555) 849-9075	3 4
	10 11
Frontline Support	17 18

ACCESSING ABSENCE MANAGEMENT ON THE PHONE

Not only is Frontline’s absence management on the web but you can also create absences, manage personal information, check absence reason balances, and more, all over the phone.

To call the absence management system, dial **1-800-942-3767**. You’ll be prompted to enter your ID number (followed by the # sign), then your PIN number (followed by the # sign).

Over the phone you can:

- Create an absence (within the next 30 days) – **Press 1**
- Check your absence reason (entitlement) balances – **Press 2**
- Review upcoming absences – **Press 3**
- Review a specific absence – **Press 4**
- Review or change your personal information – **Press 5**

If you create an absence over the phone, be sure to make note of the confirmation number that the system assigns the new absence for reference.





Absences

Closed Day

In-Service Day

Create Absence

0 Scheduled Absences

0 Past Absences

July 22

July 2019

SUN MON TUE WED THU FRI SAT

July 2019

Substitute Required

Yes

Absence Reason

Time

Please enter a valid time range using the HH:MM:AA format.

Notes to Administrator

(Not viewable by Submitter)

Select One

Select One

Dock Day

Jury Duty

Personal

Professional

Sick Leave

Vacation (12 month o

WE - Assault Leave

WE - Other Leave

WE - Professional

WE - Sick Leave

Helpful Hint:

You can select multiple days individually or click-and-drag to select a range of dates.

Scroll down below the calendar and select the 'Create Absence' tab. You will click the date(s) > select the absence reason > write any notes- if needed > click 'Create Absence' green button.

ESC Employees use the following codes:

Dock Day
Jury Duty
Personal
Professional
Sick Leave
Vacation (12 month only)

Wixey Employees use the following codes:

WE- Assault Leave
WE- Other Leave
WE- Professional
WE – Sick Leave

Create Absence

0 Scheduled Absences

0 Past Absences

July 22

July 2019

SUN	MON	TUE	WED	THU	FRI	SAT
				18	19	
22	23	24	25	26		
29	30	31	1	2		

Substitute Required

Yes

Absence Reason

WE - Sick Leave

Time

Please enter a valid time range using the HH:MM-AM format

Full Day

08:00 AM to 02:30 PM

Notes to Administrator

(not viewable by Substitute)

Notes to Substitute

Helpful Hint:

You can select multiple days individually or click-and-drag to select a range of dates

Cancel

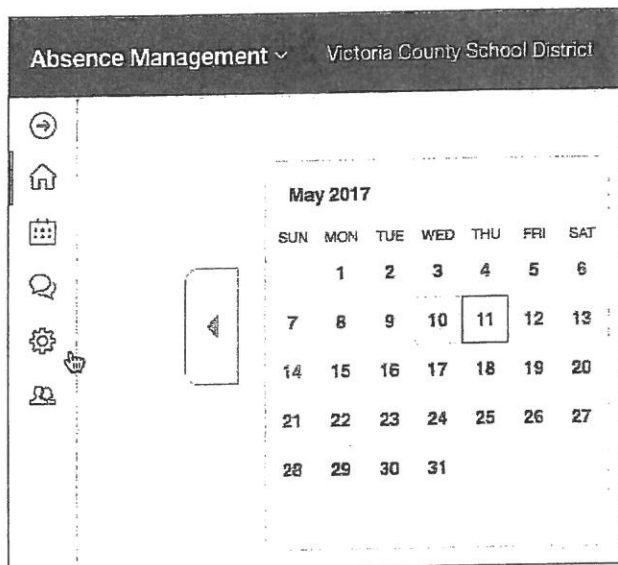
✓ Create Absence

Once you click the green button, the absence will save and you will get a confirmation (like below). If you do not get a confirmation the absence did not go through.

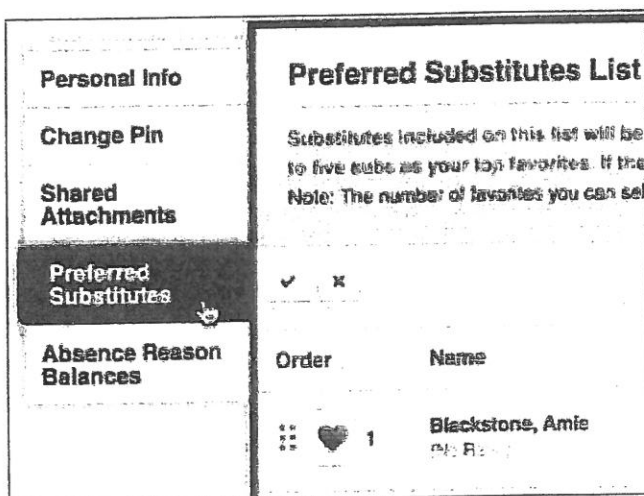
Managing Preferred Subs Lists

Your district may have given you the ability to select a list of the substitutes you prefer to fill your absences. The substitute placement feature will attempt to contact these substitutes first when you create an absence.

To access the "Preferred Substitutes" page, click the **Account** option in the side navigation.



Now click on the **Preferred Substitutes** tab.



Adding Substitutes

To add a substitute, click the **Add Substitute(s)** button.

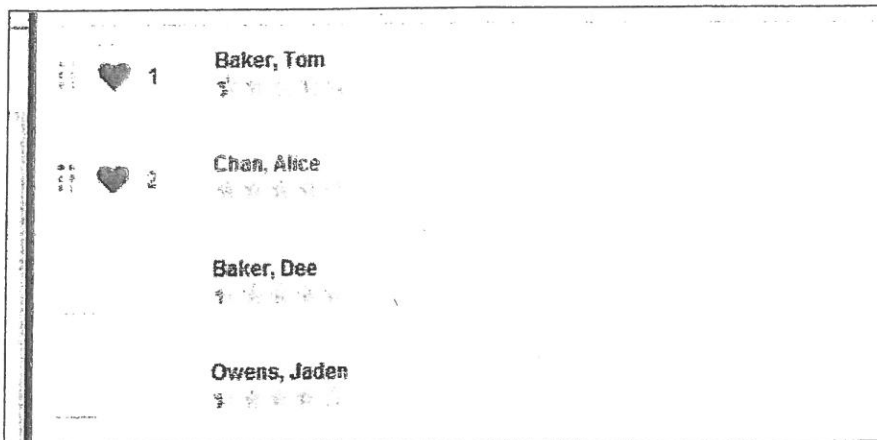
Preferred Substitutes	Add Substitute(s)	
Absence Reason Balances	Order	Name
		Select

This will open up the substitute selection page. Here, you can find the substitutes you want by searching by the substitute's last name, filtering by the first letter of the substitute's last name, or just browsing the list of substitutes.

Add Substitutes		
Search:	Back to Preferred Substitutes <input checked="" type="checkbox"/> Add to Preferred Substitutes	
Search by Letter	Select Substitute Name SELECTED SUBSTITUTES	
A B C D E	<input type="checkbox"/> Baker, Dee	Baker, Dee
F G H I J	<input type="checkbox"/> Owens, Jaden	Owens, Jaden
K L M N O	<input type="checkbox"/> Hudson, Ben	
P Q R S T	<input type="checkbox"/> Owens, Jaden	
U V W X Y	<input type="checkbox"/> Wen, Julie	
Z All		

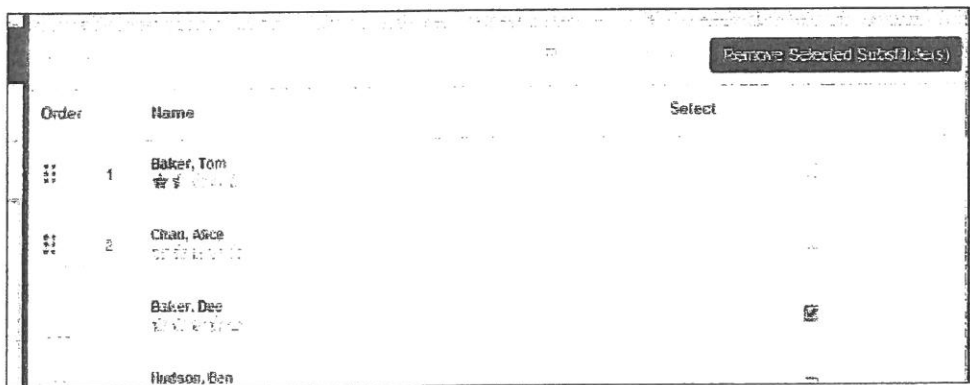
Back to Preferred Substitutes ☒ Add to Preferred Substitutes

Select the substitute(s) that you would like to add to your Preferred Substitutes list by checking the box next to their names. Once you have finished selecting the substitutes, click the **Add to Preferred Substitutes** button. This will add the substitutes to your Preferred Substitutes list.



Removing Substitutes

To remove a substitute from your Preferred Substitutes list, click the check box for the substitute you would like to remove. The **Remove Selected Substitute(s)** button will appear. Click that button.



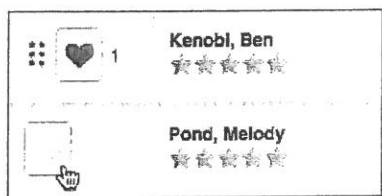
The substitute will be removed from your Preferred Substitutes list.

Managing Your Favorite Five Substitutes

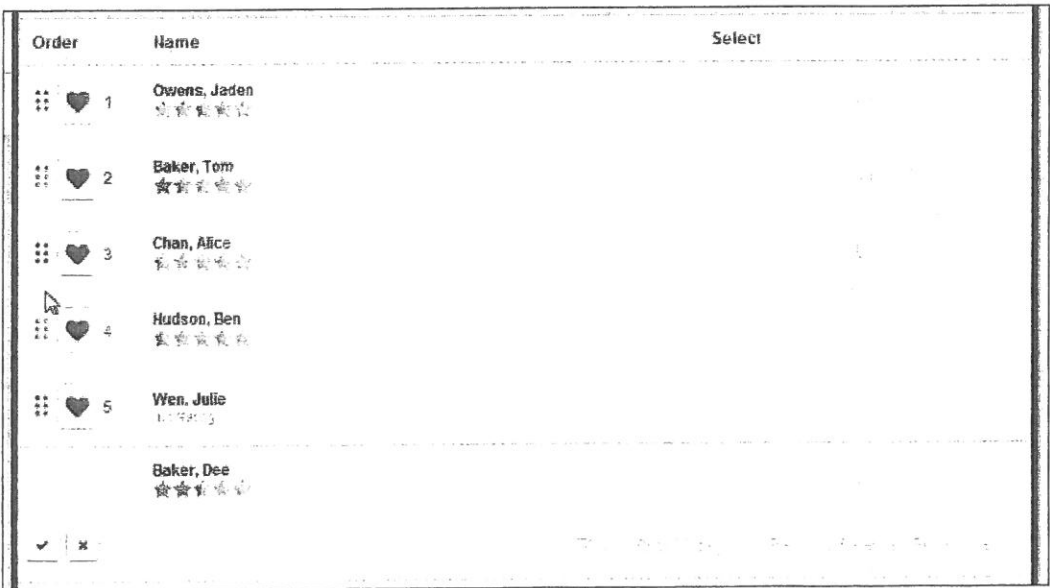
Once you have added a number of substitutes to your Preferred Substitutes list, you can select up to five of them to be your "Favorite Five". The Favorite Five will get even more of an advantage when attempting to fill your absences. Substitutes that are marked as favorites, and who are considered "qualified and available" at the time the absence is created, will be notified instantly by email when you create an absence that needs a substitute. Also, absence management will begin calling the Favorite Five subs during the next evening calling period up to 120 nights before the absence.

Choosing Favorite Substitutes

To mark someone as a favorite, simply click the heart icon in their row in the preferred list. The heart will turn red, indicating that this substitute has been added to your Favorite Five list.

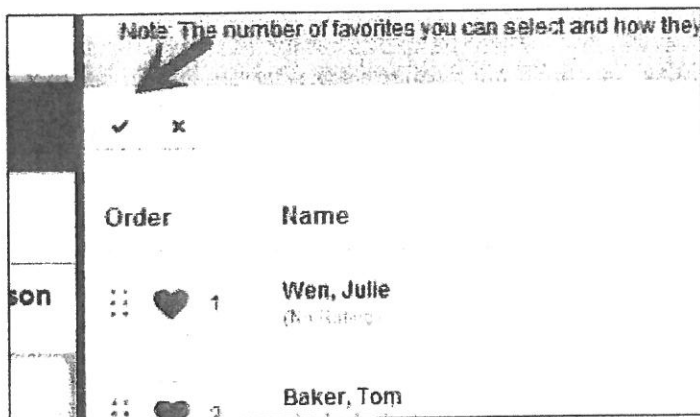


Once you have marked your favorites, you can order them by dragging them up or down in the order by grabbing the drag icon (group of dots on the left) and dragging them into the position you want them.



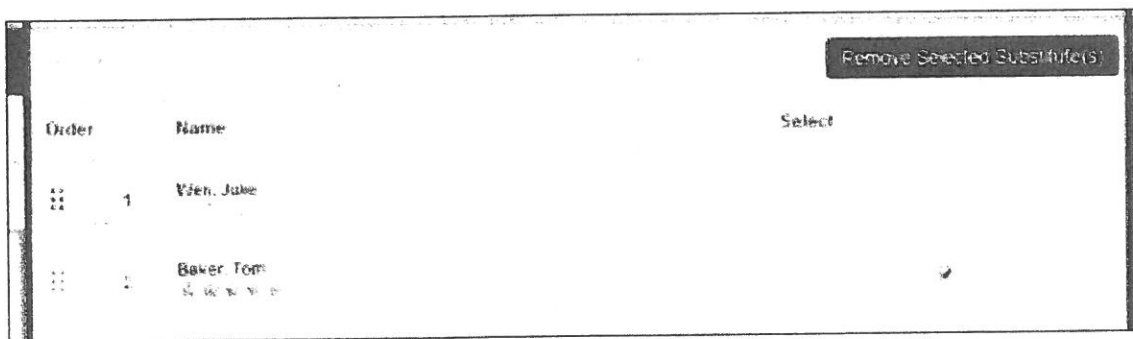
Ordering your Favorite Five will determine in what order absence management will attempt to contact them when making calls.

When you've finished re-ordering the substitutes to your liking, click the **Check Mark** button to save the changes.



Removing Substitutes from Favorites

To remove a substitute from your Favorite Five list, click the check box for the substitute you would like to remove. The **Remove Selected Substitute(s)** button will appear. Click that button.



That's it! Now you have your Favorite Five list set up the way you want.

Appendix B

Annuity Options

APPENDIX I
Approved 403(b) Investment Option Providers
Effective Date 06/05/2019
PUTNAM COUNTY EDUCATIONAL SERVICE CENTER

<u>Provider Name</u>	<u>Provider Contact</u>	<u>Provider Telephone</u>
AMERICAN FIDELITY ASSURANCE	CUSTOMER SERVICE	(800) 662-1113
AMERIPRISE FINANCIAL SERVICES	CUSTOMER SERVICE	(800) 862-7919
ASPIRE FINANCIAL SERVICES	GROUP BILLING AND PREMIUM	(866) 634-5873

Important Notes:

1. As provided under the Plan, any authorized Vendor named in Appendix I has agreed to share information necessary for compliance purposes with Employer, an Administrator and/or with any other 403(b) provider as may be required to facilitate compliance with the Plan and all applicable laws and regulations.
2. Each Vendor named above is required to maintain records of the Funding Vehicles offered under the Plan to comply with the information sharing requirements of the Plan and applicable information sharing agreements.

This Appendix is dated: _____



OHIO DEFERRED COMPENSATION

OHIO PUBLIC EMPLOYERS DEFERRED COMPENSATION PROGRAM

We Are Here To Support You

Download a map to our Service Center, located at 257 East Town Street, Suite 457, Columbus, Ohio 43215.

The Service Center has licensed Account Executives who can help you with your account. They can assist with enrollment, deferral changes, allocation changes to your investment options, asset allocation information, and withdrawals.

Phone Hours:

Monday–Friday, 8 a.m.– 5:30 p.m. Call **877-644-6457**.

Fax:

You can fax documents and questions to us at **614-222-9457**.

Walk-in Hours:

Monday–Friday, 8 a.m.– 4:30 p.m.

Appointments:

You can make an appointment with a Retirement Planning Specialist by calling **877-644-6457**. Information provided by Retirement Planning Specialists is for educational purposes only and is not intended as investment advice.

The Service Center and exchange processing will be affected by the following New York Stock Exchange holiday schedule. When the Service Center is closed, you may still access your account by using the automated telephone system or the website.

Exchanges received on holidays will be processed as of the market close of the next business day.

Holiday	Date Closed	Exchanges Processed
Labor Day	September 5	September 6

NRW-2926OH-OH.2



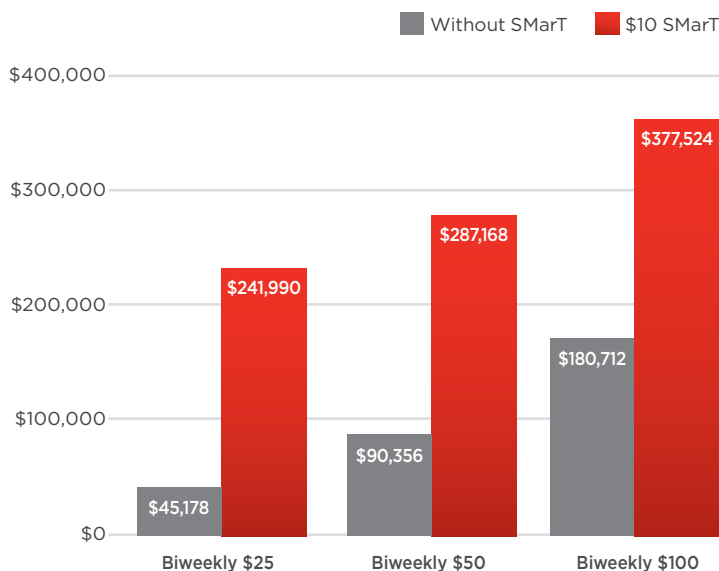
Investing for Retirement Is Smart. Now is the time to **GET STARTED.**

When you stop working, your pension will be there for you. But did you know Ohio Deferred Compensation also is available to help provide your retirement income?

Simply enroll, choose how much you want to save from each paycheck, and then let your money go to work for you.

- **It's easy.** Dollars are automatically deducted from your pay.
- **It's flexible.** You can increase or decrease the amount at any time.
- **It can reduce your current income taxes.** Taxes are deferred until you withdraw.
- **You have full control.** You can choose how your money is invested.
- **You'll have more choices.** When you leave a job, you can take your money without penalty or leave it in the plan to potentially grow. *There is no 59½ age penalty.
- **You'll get all the personalized help you need.** Account Executives are available to help you keep up with your account.

NO SMarT vs. \$10 SMarT on a current balance of \$0 with 5% compounding interest over 30 years.



These are hypothetical compounding examples and are not intended to predict or project the investment results of any specific investment. Investment return is not guaranteed and will vary depending on your investments and market experience.

Need another reason to enroll? How about a tax credit of up to \$1,000!

Savers who invest part of their salary into Ohio Deferred Compensation might be eligible for a federal income tax credit—the Saver's Tax Credit.

The credit amount ranges from **10-50%** of the first **\$2,000** invested, depending on your household income. That means you could save up to **\$1,000** on your taxes.

To enroll today, use this form, call **877-644-6457** or visit **Ohio457.org**.



**OHIO DEFERRED
COMPENSATION**

OHIO PUBLIC EMPLOYEES DEFERRED COMPENSATION PROGRAM

Neither Nationwide nor plan representatives may offer investment, legal or tax advice. Please contact your investment, legal or tax advisor for such services. Investing involves market risk, including possible loss of principal or investment.

Retirement Specialists are Registered Representatives of Nationwide Investment Services Corporation, Member FINRA. Information provided by Retirement Specialists is for educational purposes only and not intended as tax, legal, or investment advice.



TURN IN TODAY!

Fax: **614-222-9457**

Mail: Ohio Deferred Compensation
257 East Town Street Suite 457
Columbus, Ohio 43215-4626

EZ Enrollment Form

PERSONAL INFORMATION *(please print)*

Name _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Work Phone _____ Personal Phone _____

Email _____

Employer Name _____

DOB (mm/dd/yyyy) ____/____/____ Pay days per year _____

Pension System: *(circle one)* OPERS STRS SERS OP&F HPRS CINCY Other

I currently have other tax-deferred retirement assets in: *(circle any that apply)*

457 401(k) 401(a) 403(b) Traditional IRA None

☐ **I acknowledge I have read the terms and conditions detailed below.**

Signature _____

Date _____

Social Security Number _____

You will be notified by email when your Quarterly Statements and *Focus* newsletters are available at Ohio457.org.

☐ If you prefer to receive your statements and newsletters by regular mail, please check the box.

TERMS AND CONDITIONS

Upon enrolling, you will be mailed a Welcome Kit that includes the Cancellation Form, Beneficiary Form, Memorandum of Understanding, and Plan Document with more detailed information on the terms and conditions outlined below:

- Your account balance will be held by Ohio Deferred Compensation in trust on behalf of your employer for the exclusive benefit of you or your beneficiaries.
- You can cancel your participation before your forms are processed by calling 877-644-6457 within seven days of the date signed on this form.
- Based on market fluctuations, the rate of return on your account could be either positive or negative. This could result in your account balance being worth less than your contributions.
- Investments have underlying expenses or management fees that will reduce the investment results. Information on these expenses can be found in the fund profiles or the respective prospectus. Call 877-644-6457 to receive fund profile or prospectus.
- Before investing, carefully consider the fund's investment objectives, risks, charges, and expenses. The fund prospectus or profile contains this and other important information. Read the prospectus or profile carefully before investing.
- The Internal Revenue Service imposes rules that limit the times you can make changes or receive withdrawals from the Program.
- At any time, you may change the amount you defer or the allocation of future investment options.

ENROLLMENT INSTRUCTIONS

1. ☐ I want to enroll in the Program today and begin contributing:

☐ \$50 per pay period or

☐ \$ _____ per pay period

A pre-tax deduction will be invested into the LifePath Portfolio closest to the year turn 65. My payroll deductions will begin on the next pay period following 30 days from the date my form is received by Ohio DC.

2. ☐ Unless I check this box, I will be enrolled in the SMarT plan to automatically increase my deferrals each January by \$10 or \$ _____ each pay period.

- You may withdraw funds from the Program only upon: 1. Ending your employment (including termination, retirement, or death) 2. An Unforeseeable Emergency (as defined by Section 457 of the IRC) 3. Small Balance Distribution (see Plan Document for eligibility)
- Withdrawals may begin after ending your employment and the Program's receipt of your employer's verification that employment ended, final deferral, and the Withdrawal Election Form.
- Distributions must satisfy certain minimum requirements upon attaining age 70 ½.
- The funds in your account may be eligible for rollover to a traditional IRA or to an eligible retirement plan upon ending your employment.
- Your participation in Ohio DC is for long-term retirement savings. You should maintain separate, available emergency funds to cover day-to-day, unanticipated, financial shortages.
- An Unforeseeable Emergency is defined by the IRS as a severe financial hardship. Please see the Program Plan Document for specific details. Purchasing a home, credit card debt, and sending your children to college are not qualifying events.
- Remember, there are no guarantees. Investing involves risk, including possible loss of principal.
- Account Executives are registered representatives of Nationwide Investment Services Corporation, Member FINRA.

Appendix C

Medical / Prescription
Insurance

Putnam County ESC

2024 Medical Insurance Plan Design Options

Effective 1/1/2024

	1	2
	PPO Plan	High Deductible Health Plan
Deductible	\$1,500 / \$3,000	\$2,500 / \$5,000
Coinsurance Percentage	80 / 20	90 / 10
Coinsurance Limit	\$3,000 / \$6,000	\$1,000 / \$2,000
Maximum Out-of-Pocket	\$4,500 / \$9,000	\$3,500 / \$7,000
Office Visit Copay	\$25	Deductible then Coinsurance
Emergency Room Copay	\$100 then Deductible	Deductible then Coinsurance
Retail Drug Copay	\$15 / \$40 / \$60	Deductible then Coinsurance \$15 / \$40 / \$60
Mail Order Drug Copay	\$30 / \$80 / \$120	Deductible then Coinsurance \$30 / \$80 / \$120
	FSA Compatible 85/15 Split Cost of Premium	H.S.A. Compatible 90/10 Split Cost of Premium Single: HSA Cont = \$1,000.00 Family: HSA Cont = \$2,000.00

New Monthly Employee Share: 2024		
Single:	\$136.10	\$76.14
Family:	\$351.01	\$196.39
New Monthly Employer Share: 2024		Plus H.S.A Semi-Annual Contribution
Single:	\$771.21	\$685.29
Family:	\$1,989.03	\$1,767.48

Current Monthly Employee Share: 2023		
Single:	\$136.10	\$76.14
Family:	\$351.01	\$196.39
Current Monthly Employer Share: 2023		Plus H.S.A Semi-Annual Contribution
Single:	771.21	685.29
Family:	1,989.03	1,767.48

Amount of Employee Monthly change from 2023 to 2024		
Single:	\$0.00	\$0.00
Family:	\$0.00	\$0.00
Amount of Employer Monthly change from 2023 to 2024		Plus H.S.A Semi-Annual Contribution
Single:	\$0.00	\$0.00
Family:	\$0.00	\$0.00

**MEDMUTUAL LIFE**

A Medical Mutual Company

100 American Road
Brooklyn, OH 44144-2322**Employee Enrollment Form**

Please Type or Print All Information

☐ New Enrollment ☐ Change

Effective Date

Group Number

Last Name	First Name	M.I.	Date of Birth / /	Social Security Number
Street Address	City	State	Zip Code	
Phone ()	E-mail			
Employer	Occupation/Job Title	Class	Gender <input type="checkbox"/> male <input type="checkbox"/> female	
Original Date of Hire	Date of Rehire (If Applicable)	Earnings <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$	

COVERAGE SELECTION: Your group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

BASIC COVERAGE(S)	(A)dd (D)elete	Total Amount of Coverage Applied for
Basic Life <input type="checkbox"/> YES <input type="checkbox"/> NO		
Basic AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supplemental/Voluntary Life <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supplemental/Voluntary AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO		
Short-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO		
Long-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO		
Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO		

BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for life and/or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

TERMS AND CONDITIONS

I hereby apply to MedMutual Life Insurance Company® (MedMutual Life) for the coverage indicated on this Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to MedMutual Life, and/or any affiliates or divisions of MedMutual Life; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to MedMutual Life and/or any affiliates or division of MedMutual Life: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; and/or; (c) for credentialing purposes. I authorize MedMutual Life to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application.

I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information MedMutual Life requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that is inconsistent with, or different from, any written information provided by MedMutual Life; (d) to bind MedMutual Life in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MedMutual Life to be binding on MedMutual Life.

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether intentional or not), can result in denial of a claim or rescission of coverage and may subject me to legal action by MedMutual Life; (b) to be eligible for life and/or disability income coverage, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my coverage will not begin until the day I return to work; (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.

My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MedMutual Life's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by MedMutual Life's Privacy Office.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. I understand that I should not cancel any current insurance coverage until I receive an approval letter and insurance certificate from MedMutual Life.

Employee Signature: _____ Date: _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)



MEDMUTUAL LIFE®

A Medical Mutual Company

100 American Road, Brooklyn, OH 44144-2322

Beneficiary Designation Form

Telephone: 866-925-2542

Fax: 440-878-6916

Email Address: Claims@medmutual.com

Group Number

836631

☐ Initial

☒ Change

Insured's Name	Social Security No.	Date of Birth / /
Group Name	Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
COVERAGE TYPE – The Beneficiary designation will apply to all death benefits for the above named Insured, unless they designate otherwise by checking a specific coverage: <input type="checkbox"/> Basic Term Life <input checked="" type="checkbox"/> Basic AD&D <input type="checkbox"/> Supp Life <input type="checkbox"/> Supp AD&D <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary AD&D <input type="checkbox"/> All		

Definitions:

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. *If you specify benefit percentages, the total must equal 100%.* If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. *If you specify benefit percentages, the total must equal 100%.*

PRIMARY BENEFICIARY(IES):

In accordance with the provisions of the Policy and/or Certificate, I hereby request the benefits payable for loss of life to be issued as follows:

First Name	Last Name	Date of Birth	Relationship	Benefit %
		/ /		
		/ /		
		/ /		
		/ /		

CONTINGENT BENEFICIARY(IES):

First Name	Last Name	Date of Birth	Relationship	Benefit %
		/ /		
		/ /		
		/ /		
		/ /		

I hereby revoke all former beneficiary designations and I reserve the right to make further changes at any time, subject to Policy provisions.

Signature of Insured

Date Signed

Important Note for Married Employees: If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, and you name someone other than your spouse as primary beneficiary, your spouse's consent will be necessary to allow your spouse to waive his or her rights to any community property interest in the benefits. We have provided a space below for your spouse's signature. Payment of this benefit may be delayed or disputed unless your spouse signs below.

Spousal Consent for Community Property States Only: I hereby consent to the Primary Beneficiary designated by my spouse and understand that this consent supersedes any prior spousal consent under this plan.

Signature of Spouse

Date Signed

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

PERSONAL INFORMATION					
Name*		SSN*			
Physical Address*		DOB (mm/dd/yyyy)*			
City, State, Zip*		Marital Status		Single <input type="checkbox"/> Married <input type="checkbox"/>	
Mailing Address (if different)		Driver's License #*			
City, State, Zip		Issuing State*			
Home Phone		Work Phone		Cell Phone	
Email address*					

Important Information about Procedures for Opening a New Account:

* Required fields

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open an HSA, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. Your identity may be verified through the use of a database maintained by a third party. If your identity cannot be verified, you may be asked to provide additional information or your HSA may be closed. Upon such closure, funds deposited in your HSA will be returned, and we shall not be liable for any tax consequences of transfer or distribution of your assets as a result of this distribution. If additional debit cards are requested, the same procedures apply to those individuals.

HEALTH PLAN INFORMATION					
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.)			<input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by any other non-permitted health plan (i.e. Health FSA, spouse's non-HDHP medical plan)?		
Carrier Name			<input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by Medicare?		
Effective date of HDHP		Yearly Deductible	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you claimed as a dependent on another person's tax return?		
Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family			If you answered yes to any of the questions above, you are not eligible to establish an HSA. See IRS Publication 969 for specific information.		

EMPLOYER INFORMATION			
Company Name*		Contact	
Address		Telephone Number	
City, State, Zip		Date of Employment	

CONTRIBUTION INFORMATION				
Requested effective date for the HSA: _____				
(The requested effective date cannot be before the date this application is signed, effective date of coverage under the HDHP, or the date you are eligible to contribute to an HSA.)				
Contribution	Annual	Per Pay Period	Pay Period (if applicable)	Annual maximums are updated each year by the IRS. For additional information on what may affect your annual allowable contribution(s) or to find out the allowable maximum contribution amount, please log in to your online account and review the details under "Resources"
Employer	\$ _____	\$ _____	<input type="checkbox"/> Monthly	
Individual	\$ _____	\$ _____	<input type="checkbox"/> Bi-monthly	
Catch-up Contribution	\$ _____	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	

REQUEST FOR BENEFITS DEBIT CARD

Would you like a Benefits Debit Card to use with your HSA? ☐ Yes ☐ No

Would you like an additional card for use by an authorized user – either a spouse or an eligible dependent*? ☐ Yes ☐ No

*Dependent must be 18 years or older. **Required field for additional card.

Name**		Relationship	
SSN**		DOB(mm/dd/yyyy)**	

A MasterCard® issued by The Bancorp Bank (Member FDIC) (pursuant to a license from MasterCard International) will be mailed to your address shown above, and will contain your Benefits Debit Card and a Cardholder Agreement for your review and review by any additional cardholder. This card will "stack" with other reimbursement accounts you may have through American Fidelity so that all accounts will be included on the single card. If you already have a Benefits Debit Card, you will use that card for the HSA as well, and you will not receive a separate card for the HSA.

BENEFICIARY INFORMATION

Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip		SSN		____%	Percent

Back-Up Withholding Certificate

I hereby certify under penalties of perjury that: The social security number shown on this form is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (please check the appropriate box):

- ☐ I am not subject to withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
- ☐ I am subject to backup withholding.

Consent to Receive Electronic Notices

In order to apply for an HSA, you must consent to receive documents and notices related to your HSA in electronic form. Your consent will apply both at the time of enrollment and in the future. The documents and notices you agree to receive in electronic form include the following: enrollment forms, Health Savings Account (HSA) Custodial Agreement; disclosures relating to Truth in Savings and funds availability policies; American Fidelity Assurance Company privacy policy; documents issued by mutual fund and insurance companies, including prospectuses and trade confirmations; IRS Tax Forms 1099-SA and 5498-SA; account summaries; and confirmation of your online or telephonic instructions or elections. **Your consent will continue to apply until you are no longer an accountholder or until you withdraw consent as provided below.**

If you wish to withdraw your consent to electronic delivery of notices, you may call Customer Service at (800) 662-1113. Confirmation of your withdrawal will be in writing (electronically or on paper). Additional fees may apply for paper copies of applicable notices (see fee schedule). Investment options may not be available if you do not consent to receive prospectuses, trade confirmations and related documents in electronic form. We reserve the right to close your account if you withdraw your consent to electronic delivery of notices.

By instructing American Fidelity Assurance Company to open the HSA, contributing funds to the HSA or otherwise using the HSA, I acknowledge that I have reviewed and consent to the terms of the Health Savings Account Custodial Agreement, which includes all cash, investment and other supplemental terms and conditions referenced therein.

Signature of Account Holder

Date

This application will be null and void if altered in anyway.

H S A Contributions for 2024

ESC
Contribution

Name: _____

Coverage: Famil \$ 2,000.00

Account # _____

Single \$ 1,000.00

Number of pays : 24 total

Pay dates -- Optional front
loading of H S A account

Employee
Contribution

January, 2024 _____

1st Board Contriution

First quarter per pay _____ X 6 _____

Second quarter per pay _____ X 6 _____

June, 2024 _____

2nd Board Contribution

Third quarter per pay _____ X 6 _____

Fourth quarter per pay _____ X 6 _____

Total for 2024 _____ + _____ = _____

2023
IRS Max
per year

F \$ 8,300.00

S \$ 4,150.00

Grand
Total

over 55 \$ 1,000.00

extra

Signature _____

Date _____

HEALTH SAVINGS ACCOUNT REQUEST FOR DEPENDENT DEBIT CARD

Enter the information via your keyboard, print the form, sign it and fax it to the number above.

A. General Information			
Name		SSN	
Address		DOB (mm/dd/yyyy)	
City, St, Zip		M or F	<input type="checkbox"/> Male <input type="checkbox"/> Female
email address		Day Phone	
Employer Name*		Home Phone	

*If HSA was established separate from your employer, employer name is not needed

B. Dependent Information			
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	

*Dependent must be 18 years or older.

There is a \$10.00 fee for each dependent debit card after the two initial cards. The fee will be automatically deducted from your health savings account. If there are not sufficient funds in your account, your request will not be processed until your next contribution is received.

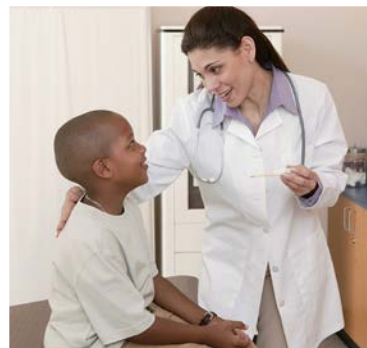
The account holder named above requests that the dependent(s) listed above receive a secondary debit card to access the account holder's health savings account. By signing this request, the account holder acknowledges that the account holder's Custodial Agreement and all applicable regulations that apply govern the secondary card(s).

Account Holder's Signature

Date Signed



Health Savings *Accounts*



A M E R I C A N
F I D E L I T Y

Health Services *Administration*

An Affiliate of American Fidelity Assurance Company

The American Fidelity Way:

Knowledge, Experience, Commitment

American Fidelity Assurance Company (AFA) is a pioneer in administering Section 125 flexible benefit plans. Putting our knowledge and know-how to work for you is what we do best.

Perhaps most important, Health Services Administration, LLC dba American Fidelity Health Services Administration (AFHSA) is an independent HSA administrator. No matter who your comprehensive medical provider may be, we are here to help. We handle your HSA administration needs while you make medical plan decisions based on your best interests. The power is yours, the work is ours.

The bottom line when it comes to you and your family is that you would do almost anything to guarantee your family's health and safety. But, these days it seems that the cost of staying well does not help maintain a healthy bottom line for the average household. Especially when you consider the rising costs of health care and the pinch of health plan restrictions that makes it harder to get the care you seek.

What if there was a way to save for medical expenses – even into retirement – and get away from the red tape of traditional medical plans to gain freedom of choice and quality protection? Don't wait for tomorrow, the answer is here today: Health Savings Accounts (HSAs).

Consider the advantages this medical savings option can provide you:

1. Invest in Yourself

- You can make contributions and get an “above-the-line” tax deduction.
- Balances roll over from year to year. There is no “Use or Lose” rule.

- Contribution dollars are invested in interest-bearing accounts.

2. Flexibility

- HSA dollars can pay for “qualified medical expenses” as defined by the Internal Revenue Code. Eligible expenses include: deductibles, co-payments, dental and vision expenses, and doctor appointments that are not covered by other insurance.
- You decide how much to put into your HSA, what medical expenses to pay from the account, whether to invest, and which investments to make.
- You take part in your health care and provider decisions while choosing the best way to spend your hard-earned dollars.
- Use funds to pay for current medical expenses or save money for future needs.

3. Portability

- No matter where you go, your account will follow.
- Even if you change jobs, change medical coverage, become unemployed, move to another state, or change your marital status, your HSA goes with you.
- You own it!

4. Tax Savings

- The three-tiered tax savings are hard to beat
 1. Tax-free contributions
 2. Tax-free distributions for qualified medical expenses
 3. Tax-free growth

LEARN MORE...



Get to Know American Fidelity Health Services Administration



American Fidelity Health Services Administration (AFHSA) is proud to be a member of the American Fidelity family of companies. American Fidelity Assurance Company is a family-owned organization with a 50-year history of providing our customers with sound financial security solutions. We are proud of our association with one of the top-rated insurance companies in the nation¹.

There is so much to learn about saving today to pay for healthcare tomorrow. With American Fidelity Health Services Administration you gain that knowledge and increase your power of opportunity by letting us help you find the options that are right for you.

What Makes Us Different?

Independence – AFHSA will be your HSA administrator no matter which insurance provider you use.

Freedom of Choice – We know that you work hard for your money, and that is why you should decide the best way to spend it. When you are not tied down by the restrictions of typical medical coverage and you decide where the dollars in your account are best spent, you gain the option to grow your savings. Plus, once your account balance reaches \$2,500, you may choose to invest your additional funds in a strong offering of mutual funds that cross all investment risk tolerances.

Maintaining Focus – We take a centralized approach, focusing on all your health savings needs from setting up your basic account to assuring you have the investment options that will work best for you.

Ease of Access – These are your funds, so accessing them should be easy. That's why we offer payment of qualified expenses through a debit card, online distribution request submission and downloadable distribution request form. Since use of HSA funds are only available if funds are in your account, these withdrawal options help you ensure that funds are available and prevent overdraft charges.

Online Access 24/7 – Our online offerings make sure you are up-to-date with your account information, offering access to:

- Account summaries
- Portfolio allocation
- Mutual fund trades
- Transaction history

Customer Service – We understand Customer Service is important to you. Our commitment is to have personnel available to assist you, not an automated response. Whether you have questions about your account or you need investment assistance, Customer Service is available to assist you at 1-866-326-3600 or 405-523-5699 or by fax at 405-523-5072 or by emailing us at hsa-support@af-group.com. And of course you have access to your account information 24/7 via our Web site, www.afhsa.com.

Account Features

We know that everyone is different, so it only makes sense that your account investments match your needs. Your funds are deposited into an interest bearing FDIC insured account. The more you save the more interest you earn. You have three convenient ways to access your funds:

- **Debit Card** - Use the debit card at different vendors, for example a doctor's office or pharmacy, to get immediate access to HSA funds for qualified medical expenses. The debit card can be used at any qualified medical provider.
- **On-line Withdrawal** - Withdrawals can be requested online either before or after an expense has been incurred. Simply indicate you want funds sent to you via check by mail or by direct deposit to one of your checking or savings accounts.
- **Withdrawal Request** – If you want us to enter the withdrawal for you, simply complete the form and mail or fax it to us.

A debit card is automatically mailed to you at the opening of your account. One additional debit card may be ordered for your spouse or a tax dependent (must be at least 18 years old) at no additional fee. If your major medical plan discounts services, you should not use your debit card at the time of service, unless you know your exact cost. Instead, when you receive a statement (EOB) from your health plan provider showing any discounted rates and applied insurance payments, you simply call the provider and give them your debit card number at that time. No need to mess with writing a check, paying for postage or remembering to mail your payment.

Investment Options

If you seek higher returns or value security, we do not charge transaction fees or broker commissions when we give you access to investment fund options that cover the spectrum of investment risks. (Fees associated with certain mutual funds may be incurred. Review the mutual funds prospectus for additional information when you are ready to invest.)

American Fidelity Health Services Administration provides a strong offering of no load mutual funds that cross all investment risk tolerances. You pick the mutual fund that best suits your needs and risk tolerance from our carefully monitored list. A minimum of at least \$2,500 must be maintained in your cash account before you may invest in the mutual funds offered.

¹ www.ambest.com/consumers (April 3, 2012) (A+ is the 2nd out of 16 with 1 being the highest)

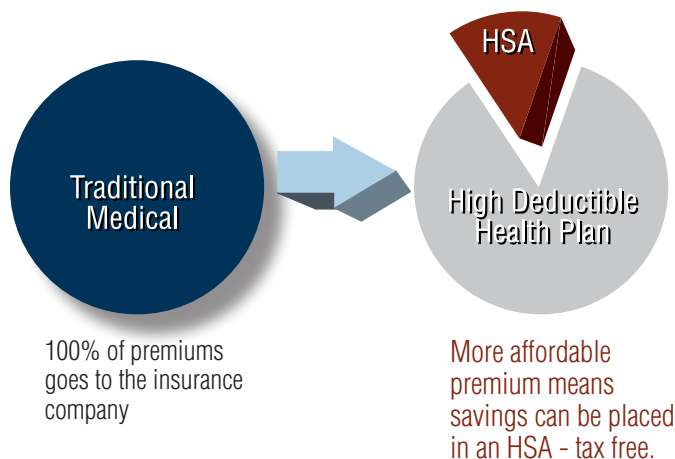
What is an HSA?

Health Savings accounts (HSAs) were created, as part of the Medicare Reform Act signed into law by Congress December 2003, to provide individuals with a Qualified High Deductible Health Plan (QHDHP) a tax free option to pay for qualified medical expenses and save for future expenses.

How Does It Work?

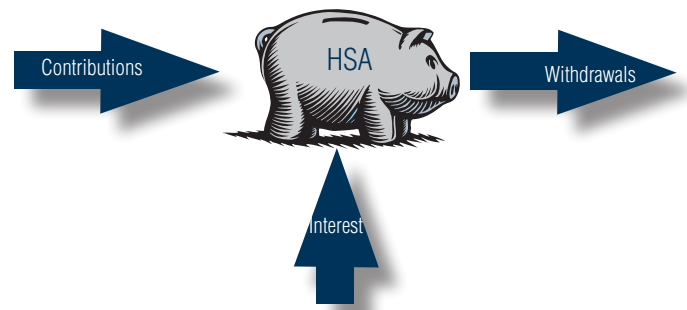
An HSA and a qualified HDHP work as partners to offer you protection in time of need while empowering you as a conscientious health consumer. First, money deposited tax-free into an HSA is used for qualified medical expenses not covered by insurance or that fall short of your plan's deductible. Next, the high deductible plan – with traditionally lower premiums – would kick in to cover any larger, qualified medical expenses should the need arise. You gain the power to choose the best way to use the money typically spent on health insurance alone and the potential to let the account grow tax-free until you need it most.

It Makes Sense for Your Dollars



The Tax Advantage

Experience the money-saving advantages whether you make a deposit, withdraw funds to cover qualified expenses, or save unused funds that rollover each year. HSAs provide a tax advantage across the board.



Tax-Free Contributions – HSA contributions are 100% tax deductible. A qualified individual may make contributions and receive an “above-the-line” tax deduction, meaning the contributions reduce the individual’s taxable income dollar for dollar. Individuals who have contributions deducted pre-tax from their paychecks through their employer sponsored Section 125/Cafeteria Plan can take advantage of tax savings each month.¹

Tax-Free Growth – Interest and investment earnings on HSA funds are generally tax-free.

Tax-Free Withdrawals – Withdrawals avoid taxation entirely when used to pay qualified medical expenses.

¹ Sole proprietors, partners or shareholders of Subchapter S Corporations can establish and contribute to an HSA on a tax advantaged basis. However, such individuals may not contribute to an HSA on a pre-tax basis via an employer’s Section 125 cafeteria plan.

Am I Eligible?

There are several items to consider in the establishment and contribution to an HSA.

- You must be covered under a “qualified high deductible health plan” (QHDHP) that meets the following guidelines. Check with your insurance carrier or employer about a QHDHP that works with a HSA.

QHDHP Requirements

	Health Insurance Plan	Annual Minimum Deductible	Annual Maximum Out-of-Pocket Expenses
2013	Self-only Coverage	\$1,250	\$6,250
	Family Coverage	\$2,500	\$12,500
2014	Self-only Coverage	\$1,250	\$6,350
	Family Coverage	\$2,500	\$12,700

Deductible must apply to all medical expenses, including prescriptions, except preventative care. Family coverage means any coverage other than self-only coverage that also covers the individual. Minimums and Maximums are indexed annually.

In addition, to be an eligible individual, you must establish that you are not:

- Being claimed as a dependent on another person's tax return.
- Covered by any other health plan¹ that is not a QHDHP.
- Covered under any other type of health benefit¹ that covers some of the medical expenses that are covered by a QHDHP
- Enrolled in Medicare²

¹ You are not eligible for an HSA if you have a 'general purpose' health Flexible Spending Account or Health Reimbursement Arrangement through your employer or your spouse's employer which allows reimbursement of your medical expenses. However, you may have a 'limited purpose' FSA or HRA which restricts reimbursements to eligible Vision and Dental expenses. In addition, your eligibility may be affected if you have access to the following: Employer's on-site clinic, VA benefits, Tri-Care or an Indian Clinic.

Note: Exceptions apply for certain limited coverage types such as worker's compensation, liability, property or casualty insurance or insurance for a specified disease or illness that covers a fixed amount per specified period of hospitalization.

² Even if you are eligible for Medicare, as long as you are not enrolled in Part A, Part B, Part C or Part D, you may establish and contribute to an HSA. Once enrolled in Medicare, you may no longer make contributions to your HSA, however, you may continue to use or save the funds already accumulated in your HSA.

For a complete list of HSA eligibility rules, see IRS Publication 969.



How do contributions work?

You, your family members, and/or your employer may make contributions to your HSA. Unused balances at the end of each year carry forward to following years and there is no limit on the total account accumulation. The following guidelines apply when making contributions.

- The maximum annual contribution you may make in any one tax year is the maximum established by law.

	Individual Coverage	Family Coverage
2013	\$3,250	\$6,450
2014	\$3,300	\$6,550

Maximums are indexed annually.

- If you are at least 55 years of age and not currently participating in Medicare you may take advantage of a catch-up contribution of \$1,000 per year. You may make the maximum annual contribution no matter when you turn 55 in the tax year.

If the effective date of your QHDHP is other than January 1, you may still make the maximum annual contribution; however, special guidelines apply.

- If you contribute the maximum allowed in any tax year where the QHDHP is in force less than 12 months, regulations require that you remain a qualified individual for every month in the tax year of the effective date of the QHDHP plus the entire 12 months of the following tax year known as the “testing period.”

- If you do not remain a qualified individual during the “testing period,” then a portion of your contributions are subject to income tax and a 10% additional tax penalty.

Example: You purchased QHDHP Self-Only Coverage effective 09/01/13.

You may contribute the maximum of \$3,250 in 2013 even though your QHDHP was not in effect during the entire 2013 tax year.

You will need to remain a qualified individual from 09/01/13 through 12/31/14 to avoid income tax and penalties on the contributions.

Let's say you lost your status as a qualified individual as of 03/01/14, the total contributions attributed to the 2013 tax year, less the prorated monthly contributions that were allowed for the months that you were eligible to contribute to an HSA, are subject to income taxes and a 10% additional tax penalty. (The excess funds are allowed to remain in the HSA - withdrawing them for a reason other than to pay for qualified medical expenses would increase the penalty by an additional 20%.)

- The income tax and the 10% additional tax penalty, will not apply if an individual becomes disabled or dies during the “testing period.”
- You can avoid the “testing period” requirements if you pro-rate your contributions based on the number of months you are covered by a QHDHP in any given tax year. To take the example above, an individual would calculate the maximum contribution as follows: $\$3,250 \div 12 \text{ months} = \$270.83 \times 4 \text{ months of QHDHP coverage (09/01/13-12/31/13)} = \$1,083.32$.



How do I use my HSA?

You may use money from your HSA to pay for qualified medical expenses for yourself, your spouse or your tax dependent children even if they are not covered under a QHDHP. Qualified medical expenses, as defined by Internal Revenue Code Section 213(d), include deductibles, hospital care, vision care, doctor visits, prescriptions, dental care, and over-the-counter medication to name just a few. Over-the-counter drugs and medicines will only be considered qualified medical expenses if prescribed by a medical practitioner.

You may use the money from your HSA at any time once the HSA is established, for qualified medical expenses incurred after the establishment of your HSA, and as long as funds are available in the account. And even if you decide not to make withdrawals from your HSA for qualified medical expenses at the time they are incurred, you can always make withdrawals for these expenses anytime in the future. For the most part, other health insurance premiums, including dental and vision care premiums, are not qualified expenses. Exceptions to this rule include:

- Long-term care coverage subject to limits established by regulations,
- Health plan coverage while receiving unemployment benefits,
- COBRA continuation coverage, and
- For those age 65 or older, any tax-deductible health insurance¹, other than a Medicare supplemental policy.

¹ Qualified expenses from an HSA for individuals enrolled in Medicare include premiums and out of pocket expenses, but do not include Medigap premiums



What is the tax treatment of an HSA ?

1. The funds within the HSA belong to you tax-free based on the qualifications outlined in the law and regulations.
 2. As with any deduction you claim on your income tax return, keep your receipts for withdrawals you make from your HSA to show money was withdrawn for qualified expenses that were not reimbursed from other sources.
 3. Funds withdrawn for any other reasons are taxable as income and subject to an additional 20% penalty. After age 65, funds withdrawn are taxable at the normal income tax rate but no penalty applies.
 4. You can take an 'above-the-line' tax deduction on your Form 1040 for your contributions (even if you do not otherwise itemize).² If you contribute to your HSA through your employer's Section 125 plan, your contributions are made on a pre-tax basis, so you may not deduct them on Form 1040.
- ² Always check with your tax advisor to ensure the application of any rule to your specific situation.

American Fidelity Health Services Administration:

American Fidelity Health Services Administration (AFHSA) has been an independent HSA provider since 2005. Our independence means that, unlike many other HSA trustees that are integrated with the major medical plan, we give you more flexibility to make changes to your medical plan insurer or administrator without the need to change HSA providers and affect your HSA. Additionally, AFHSA gives consumers the opportunity to drive your health care decisions and provide the tools, resources and services needed to ensure that you are taking advantage of what an HSA has to offer.

Our team of specialized individuals in the world of HSAs and their relationship with a High Deductible Health Plan, provide every customer personal attention and a wealth of options to meet their individual needs. Easy 24-hour online access and investment opportunities that fit your requirements make AFHSA the right choice.

American Fidelity Health Services Administration is an affiliate of American Fidelity Assurance Company(AFA). A third-generation, family-owned organization, AFA provides insurance products and financial services to education employees, trade association members and companies throughout the United States and across the globe.

Since 1982 AFA has been rated "A+" (Superior)¹, by A.M. Best Company, considered one of the nation's leading insurance company rating services. A.M. Best bases its ratings on an analysis of the financial condition and operating performance of insurance companies in such vital areas as: Competency of Underwriting, Control of Expenses, Adequacy of Reserves, Soundness of Investments and Capital Sufficiency. American Fidelity Assurance Company received Weiss Ratings' B+ rating, which places AFA in the top 16.3 percent of companies in the industry.²

Here for you today and always, American Fidelity Health Services Administration is dedicated to serving our customers and their investments with the respect they deserve.

¹ www.ambest.com/consumers (April 3, 2012) (A+ is the 2nd out of 16 with 1 being the highest)

² www.weissratings.com (January 13, 2012) (B+ is the 4 out of 16 with 1 being the highest)

Neither American Fidelity Health Services Administration nor American Fidelity Assurance Company provide tax advice. For questions about HSA eligibility, tax treatment of an HSA or HSA distributions, or HSA questions related to filing your taxes, contact your tax advisor and/or visit www.irs.gov.



For more information, consult:



A member of the American Fidelity Group®

2000 N. Classen Blvd, Ste 7E

Oklahoma City, OK 73106

www.afhsa.com



Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.

Required sections are marked with an *.

Underwritten by Combined Insurance Company of America

New York Residents only: Combined Life Insurance Company of New York

The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

Employer Information: to be completed by Employer

Employer Name*											Effective Date**					
Group Number*											Subgroup*			Class	Plan	
Location Code										Division Code						

*Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Employee Information: to be completed by Employee

Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Member ID:														
Last Name*											Date of Birth*				
First Name*	MI	Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number												
Street Address*															
City*															
State*															
Zip Code*															
Social Security Number**															
Employee Email Address:															

**Last four digits of Employee's Social Security Number are required.

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1	Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update													
	Relationship*: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner													
Last Name*											Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			
First Name*	MI	Social Security Number			Date of Birth*									
Dependent 2	Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update													
	Relationship*: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner													
Last Name*											Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			
First Name*	MI	Social Security Number			Date of Birth*									
Dependent 3	Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update													
	Relationship*: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner													
Last Name*											Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			
First Name*	MI	Social Security Number			Date of Birth*									
Dependent 4	Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update													
	Relationship*: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner													
Last Name*											Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female			
First Name*	MI	Social Security Number			Date of Birth*									

Employee Signature*: _____

Date*: ____ / ____ / ____

For additional dependents, please complete a second form.

2024 Plan Year	Super Med Plus - PPO Plan		Super Med Plus - H.S.A Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
WELLNESS (Routine Care)	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Healthcare Reform Preventive Benefits	100%	60% after deductible	100%	60% after deductible
Preventive Care Tests Well Child Care Immunizations	60% after deductible 60% after deductible 60% after deductible	100% 100% 100%	60% after deductible 60% after deductible 60% after deductible	
	Please see full Preventive Care list online w/		Please see full Preventive Care list online w/ MMO	
MAJOR MEDICAL				
Deductible	\$1,500/Individual \$3,000/Family (Embedded)	\$3,000/Individual \$6,000/Family	\$2,500/Individual \$5,000/Family (Aggregate)	\$5,000/Individual \$10,000/Family
Coinsurance	80%	60%	90%	60%
Coinsurance Out of Pocket Limits	\$3,000/Individual \$6,000/Family	\$6,000 \$12,000	\$1,000/Individual \$2,000/Family	\$2,000 \$4,000
Max Out of Pocket (MOOP)	\$9,450 / \$18,900 (Medical and Rx Copays)		\$3,500 / \$7,000 (Deductible, Coinsurance, Copays)	
HOSPITAL BENEFITS	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Out-Patient	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
In-Patient	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
SURGICAL BENEFITS	Plan Pays	Plan Pays	Plan Pays	Plan Pays
In-Patient	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
Out-Patient (other than in the Physician's office)	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
OFFICE VISITS / ER / Urgent Care	You Pay	Plan Pays	Plan Pays	Plan Pays
Primary Care Physician	\$25 Copay	60% after Deductible	90% after deductible	60% after Deductible
Virtual Telemedicine w/ PCP	\$25 Copay	60% after Deductible	90% after deductible	60% after Deductible
On Demand Telemedicine	\$25 Copay	60% after Deductible	90% after deductible	60% after Deductible
Specialist	\$25 Copay	60% after Deductible	90% after deductible	60% after Deductible
ER	\$100 Copay, waived if admitted	60% after Deductible	90% after deductible	60% after Deductible
Urgent Care	\$25 Copay	60% after Deductible	90% after deductible	60% after Deductible
DIAGNOSTIC X-RAY & LABORATORY SERVICES	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Out-Patient	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
PRESCRIPTION DRUG CARD	Retail / Mail Order or 90-day Supply		Retail / Mail Order or 90-day Supply	
Generic	\$15 / \$30		Deductible then, \$15 / \$30	
Preferred Brand	\$40 / \$80		Deductible then, \$40 / \$80	
Non-Preferred Brand	\$60 / \$120		Deductible then, \$60 / \$120	
Specialty	\$60 / Not Available		Deductible then, \$60 / Not Available	
MENTAL DISORDERS & SUBSTANCE ABUSE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
In-Patient / Out-Patient	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits
Office Visits	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits	Benefits paid based on Corresponding Medical Benefits
Outpatient Therapy Visits	You Pay	Plan Pays	Plan Pays	Plan Pays
Chiropractic (12 visits per benefit period)	\$25 Copay	60% after deductible	90% after deductible	60% after deductible (Limited to 30 Visits per benefit period)
Occupational / Physical Therapy (40 visits per benefit period)	\$25 Copay	60% after deductible	90% after deductible	60% after deductible
Speech Therapy (20 visits per benefit period)	\$25 Copay	60% after deductible	90% after Deductible	60% after deductible
Cardiac Rehabilitation (20 visits per period)	\$25 Copay	60% after deductible	90% after deductible	60% after deductible



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-540-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [MedMutual.com/SBC](https://www.MedMutual.com/SBC) or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,500/single Network \$5,000/single Non-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,500/single Network \$7,000/single Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket</u> limit must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist visit</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Diagnostic test</u> (blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.truescripts.com	Pharmacy Benefits Manager	TrueScripts		None
	Generic copay - retail Tier 1	\$15 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Generic copay - home delivery Tier 1	\$30 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - retail Tier 2	\$40 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - home delivery Tier 2	\$80 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - retail Tier 3	\$60 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - home delivery Tier 3	\$120 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	<u>Specialty drugs</u> - retail	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.
	<u>Specialty drugs</u> - home delivery	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/ surgeon fee (inpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(limit applies to Non- <u>Network</u> only), (30 visits per benefit period)
	<u>Rehabilitation services</u> (Physical Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Occupational Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Speech Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [cciio.cms.gov](https://www.cciio.cms.gov). Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](https://www.HealthCare.gov) or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-540-2583.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for sample medical situations, see the next section-----

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$3,560
-----------------------------------	----------------

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$30

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$2,950
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$30

What isn't covered

Limits or exclusions	\$0
----------------------	-----

The total Mia would pay is	\$2,530
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Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice



they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

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Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

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MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-540-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [MedMutual.com/SBC](https://www.MedMutual.com/SBC) or call 800-540-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,500/single, \$3,000/family Network \$3,000/single, \$6,000/family Non-Network	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Coinsurance Limit: \$3,000/single, \$6,000/family Network \$6,000/single, \$12,000/family Non-Network Out-of-pocket Limit: \$9,450/single, \$18,900/family Network \$15,800/single, \$31,600/family Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a network provider ?	Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	40% coinsurance	None
	Specialist visit	\$25 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance does not apply to out-of-pocket limit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	20% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.truescripts.com	Pharmacy Benefits Manager	TrueScripts		None
	Generic copay - retail Tier 1	\$15	Does Not Apply	Covers up to a 90-day supply.
	Generic copay - home delivery Tier 1	\$30	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - retail Tier 2	\$40	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - home delivery Tier 2	\$80	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - retail Tier 3	\$60	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - home delivery Tier 3	\$120	Does Not Apply	Covers up to a 90-day supply.
	<u>Specialty drugs</u> - retail	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.
	<u>Specialty drugs</u> - home delivery	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay/visit		None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 copay/visit	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/ surgeon fee (inpatient)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	(Non- <u>Network</u> limited to 30 visits per benefit period)
	<u>Rehabilitation services</u> (Physical Therapy)	\$25 copay/visit	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Occupational Therapy)	\$25 copay/visit	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Speech Therapy)	\$25 copay/visit	40% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>		None
	<u>Hospice services</u>	20% <u>coinsurance</u>		None
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u> does not apply to <u>out-of-pocket limit</u>	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [cciio.cms.gov](https://www.cciio.cms.gov). Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](https://www.HealthCare.gov) or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-540-2583.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for sample medical situations, see the next section-----

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,200

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$3,770
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$920
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$1,600
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Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice



they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

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ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html



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What is the overall <u>deductible</u> ?	\$5,000/family Network \$10,000/family Non-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u>.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,000/family Network \$14,000/family Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, See MedMutual.com/SBC or call 800-540-2583 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist visit</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Diagnostic test</u> (blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.truescripts.com	Pharmacy Benefits Manager	TrueScripts		None
	Generic copay - retail Tier 1	\$15 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Generic copay - home delivery Tier 1	\$30 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - retail Tier 2	\$40 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand name copay - home delivery Tier 2	\$80 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - retail Tier 3	\$60 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand name copay - home delivery Tier 3	\$120 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	<u>Specialty drugs</u> - retail	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.
	<u>Specialty drugs</u> - home delivery	Applicable drug tier copay applies	Does Not Apply	Covers up to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/ surgeon fee (inpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(limit applies to Non- <u>Network</u> only), (30 visits per benefit period)
	<u>Rehabilitation services</u> (Physical Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Occupational Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(40 visits per benefit period)
	<u>Habilitation services</u> (Speech Therapy)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [cciio.cms.gov](https://www.cciio.cms.gov). Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](https://www.HealthCare.gov) or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-540-2583.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for sample medical situations, see the next section-----

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$800

What isn't covered

Limits or exclusions	\$60
----------------------	------

The total Peg would pay is	\$5,870
-----------------------------------	----------------

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,000
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
----------------------	------

The total Joe would pay is	\$5,060
-----------------------------------	----------------

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,000
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
----------------------	-----

The total Mia would pay is	\$2,800
-----------------------------------	----------------

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-540-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Interpreter Services & Nondiscrimination Notice



they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711)まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Welcome to TrueScripts







Putnam County School Consortium

Prescription Benefits Guide
HDHP/HSA - Family

Welcome to TrueScripts!

TrueScripts Management Services is partnering with your employer to assist with your prescription and pharmacy benefits. We are committed to:

-  Helping you save money while providing convenient access to your prescription medications
-  Promoting the use of safe, economical, and clinically appropriate medications
-  Providing a personal and educational approach that will maximize the effectiveness of your benefits plan
-  Always delivering **Amazing Care!** Just give us a call - With over a 95% success rate, our **One Ring Response** will have you speaking with a live TrueScripts professional on the very first ring of the phone.

Our team is readily available
Monday – Friday from 8AM – 6PM (EST)

Give us a call
1-844-257-1955

or

Visit Our Website
www.truescripts.com

This guide, along with the TrueScripts Member Portal and Member Care team, is a key resource. We encourage you to review and reach out as needed to educate yourself on your prescription benefits plan.

Understanding how your plan works will help you get the most out of your benefits.



For 24/7 access to your prescription benefits information and helpful resources, be sure to register with the [TrueScripts Member Portal](#).

Follow Us!



www.facebook.com/TrueScripts



www.twitter.com/TrueScriptsPBM



www.linkedin.com/company/TrueScripts

Prescription Benefits At-A-Glance: HDHP/HSA - Family

Co-Pay Structure

Drug Type	1 - 30 Day Supply	31 - 90 Day Supply
Generic	100% until deductible met, then \$15 copay	100% until deductible met, then \$30 copay
Preferred Brand	100% until deductible met, then \$40 copay	100% until deductible met, then \$80 copay
Non-Preferred Brand	100% until deductible met, then \$60 copay	100% until deductible met, then \$120 copay
Specialty	100% until deductible met, then \$60 copay	Not Available

Annual Maximums

Deductible	Out of Pocket	Notes
\$5,000 - individual	\$7,000 - individual	Rx & Medical Combined
\$5,000 - family	\$7,000 - family	

Pharmacy Network

Retail Pharmacy
Open Network

KEEPING YOU CONNECTED

Member Portal

- Your Personal Plan Information & Claims History
- Real-Time Drug Price Lookup
- Pharmacy Locator
- Other Member Forms & Resources
- 24 Hours a Day, 7 Days a Week



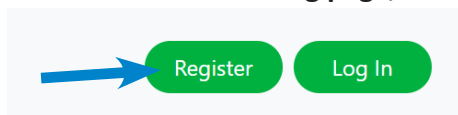
Scan above
or
Enter below

memberportal.truescripts.com **Get Started!**



TrueScripts Members, follow these instructions to register:

- Enter the URL above into your web browser to or click “Get Started” if viewing this document electronically. You can also scan the QR code from your mobile device to begin the registration process.
- On the Member Portal landing page, choose ‘Register’ from the top navigation bar.



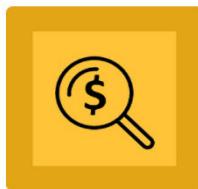
- Enter your personal information to complete the registration process.
**Note that you will need to have your Member ID card readily available*
- Check your email to verify and complete your account set-up.
- Once inside the portal, quickly access important information and helpful resources from your Member Dashboard. The Drug Price Lookup and Pharmacy Locator tools will help you find the pharmacies nearest you with the best pricing for your medications.



My Plan



My Claims



Drug Price Lookup



Pharmacy Locator

**If you have any questions along the way, please call us at the number below.
Our team is prepared to provide you with *Amazing Care!***

TrueScripts[™]
Amazing Care

We are Experts in Prescription Benefits.
Questions? Please call and speak to a care specialist who will answer your questions. **844-257-1955**

Mail Order Member Education

Members may choose to receive prescription medications via mail order pharmacy. This alternative to retail pharmacy is completely optional. Should you wish to enroll in mail order, please follow the steps below, and note that there will be no changes in your plan setup:

1. Select the Mail Order Pharmacy on the provided flyer that you would like to use for your prescriptions. Once you have selected the pharmacy, you will need to contact that pharmacy to set up an account with them. You can complete this step in one of the following methods:
 - a. Set up a profile on their website.
 - b. Call their customer service number
2. Have a list of the medications and prescribing doctors ready to input when asked.
3. Provide the pharmacy with your TrueScripts Processing information:
 - a. RxBin: 017274
 - b. RxPCN: PDMI
 - c. RxGroup: 99993996
 - d. Your Member ID number printed on your card
4. If you have current refills at another pharmacy, you can request that the mail order pharmacy call and request that they be transferred over to your new pharmacy.
5. A new prescription may be needed from your healthcare provider for 90-day fills at the retail pharmacy or mail order. The pharmacy can reach out to your provider to request this script. Since your provider should be able to call this into your pharmacy of choice, an office visit typically will not be required.
6. If the pharmacy informs you that your insurance is not contracted with TrueScripts, please request for them to call us so that we may further assist.

Mail Order Pharmacy Network

To enroll in mail order, please visit a website below:



343 Mercer Road
Greenville, PA 16125
PHONE: 844-522-CARE (2273) FAX: 844-308-1485
E-Scribe: NCPDP 6005943
carefillltc.com

***See note below**



7835 Freedom Ave NW
North Canton, OH 44720
PHONE: 1-866-909-5170 FAX: 1-866-909-5171
E-Scribe: NCPDP 3677361
envisionpharmacies.com/Mail/Patients



by pharmacy
250 Commercial Street, Suite 2012
Manchester, NH 03101
PHONE: 1-866-332-1668 FAX: 603-935-9108
E-Scribe: NCPDP 3061582
pillpack.com

***Dispenses 30-day supply only**



P.O. Box 2718
Portland, OR 97208
PHONE: 1-800-552-6694 FAX: 1-800-723-9023
NABP 3812674 – NPI 1528003910
ppsr.com

**Care-Fill mail order services are only available in the following states: AK, AZ, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KY, MI, MA, MO, MT, NJ, NM, NY, NC, ND, OH, PA, RI, SC, SD, VT, VA, WA, WI, WY.*

Maximize Your Savings

By Considering These Best Practices

90 Day Supply / Retail Pharmacy: To help cut costs and increase convenience to **you**, TrueScripts allows 90-day prescriptions to be filled at retail pharmacies nationwide. To obtain a 90-day prescription, have your prescribing provider call into your pharmacy of choice with the updated prescription; an office visit is typically not required.

Generic Medications: Generic medications provide quality, cost-effective alternatives to brand medications. Generic equivalents work the same way in the body and have the same ingredients, strength, dosage, and form as their brand-name counterparts. Unless otherwise directed by your doctor, it is a good idea to use generic equivalents when possible.

Over-the-Counter (OTC) Products: Some brand-name prescription drugs have OTC alternatives that are therapeutically identical and are likely a much lower cost option for treating your condition. When talking to your prescriber, ask if an OTC product is available. TrueScripts will also do our part to identify situations where OTC coverage will benefit both you and your health plan.

Coupons & Copay Cards: Several websites, such as goodrx.com, offer large databases of savings opportunities. Please have your pharmacy check pricing through all sources before checking out. If any of those sources provide greater savings, please select that option and submit your receipt(s) via the Electronic Drug Reimbursement form found at www.truescripts.com/members. The amount paid will be applied to your deductible and/or out of pocket, based upon plan structure.

Manufacturer websites also list additional copay assistance programs on their websites. Keep in mind that only copay cards can be used *in addition to* your TrueScripts coverage.

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How do I file a prescription claim if I didn't use my ID card at the pharmacy?

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What do I do if the pharmacy tells me a prescription has been rejected or is not covered?

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Welcome to TrueScripts







Putnam County School Consortium

Prescription Benefits Guide
HDHP/HSA - Single

Welcome to TrueScripts!

TrueScripts Management Services is partnering with your employer to assist with your prescription and pharmacy benefits. We are committed to:

-  Helping you save money while providing convenient access to your prescription medications
-  Promoting the use of safe, economical, and clinically appropriate medications
-  Providing a personal and educational approach that will maximize the effectiveness of your benefits plan
-  Always delivering **Amazing Care!** Just give us a call - With over a 95% success rate, our **One Ring Response** will have you speaking with a live TrueScripts professional on the very first ring of the phone.

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Monday – Friday from 8AM – 6PM (EST)

Give us a call
1-844-257-1955

or

Visit Our Website
www.truescripts.com

This guide, along with the TrueScripts Member Portal and Member Care team, is a key resource. We encourage you to review and reach out as needed to educate yourself on your prescription benefits plan.

Understanding how your plan works will help you get the most out of your benefits.



For 24/7 access to your prescription benefits information and helpful resources, be sure to register with the [TrueScripts Member Portal](#).

Follow Us!



www.facebook.com/TrueScripts



www.twitter.com/TrueScriptsPBM



www.linkedin.com/company/TrueScripts

Prescription Benefits At-A-Glance: HDHP/HSA - Single

Co-Pay Structure

Drug Type	1 - 30 Day Supply	31 - 90 Day Supply
Generic	100% until deductible met, then \$15 copay	100% until deductible met, then \$30 copay
Preferred Brand	100% until deductible met, then \$40 copay	100% until deductible met, then \$80 copay
Non-Preferred Brand	100% until deductible met, then \$60 copay	100% until deductible met, then \$120 copay
Specialty	100% until deductible met, then \$60 copay	Not Available

Annual Maximums

Deductible	Out of Pocket	Notes
\$2,500 - individual	\$3,500 - individual	Rx & Medical Combined
\$2,500 - family	\$3,500 - family	

Pharmacy Network

Retail Pharmacy
Open Network

KEEPING YOU CONNECTED

Member Portal

- Your Personal Plan Information & Claims History
- Real-Time Drug Price Lookup
- Pharmacy Locator
- Other Member Forms & Resources
- 24 Hours a Day, 7 Days a Week



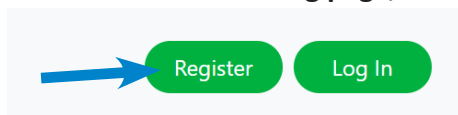
Scan above
or
Enter below

memberportal.truescripts.com **Get Started!**



TrueScripts Members, follow these instructions to register:

- Enter the URL above into your web browser to or click “Get Started” if viewing this document electronically. You can also scan the QR code from your mobile device to begin the registration process.
- On the Member Portal landing page, choose ‘Register’ from the top navigation bar.



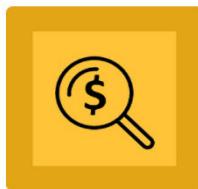
- Enter your personal information to complete the registration process.
**Note that you will need to have your Member ID card readily available*
- Check your email to verify and complete your account set-up.
- Once inside the portal, quickly access important information and helpful resources from your Member Dashboard. The Drug Price Lookup and Pharmacy Locator tools will help you find the pharmacies nearest you with the best pricing for your medications.



My Plan



My Claims



Drug Price Lookup



Pharmacy Locator

**If you have any questions along the way, please call us at the number below.
Our team is prepared to provide you with *Amazing Care!***

TrueScripts[™]
Amazing Care

We are Experts in Prescription Benefits.
Questions? Please call and speak to a care specialist who will answer your questions. **844-257-1955**

Mail Order Member Education

Members may choose to receive prescription medications via mail order pharmacy. This alternative to retail pharmacy is completely optional. Should you wish to enroll in mail order, please follow the steps below, and note that there will be no changes in your plan setup:

1. Select the Mail Order Pharmacy on the provided flyer that you would like to use for your prescriptions. Once you have selected the pharmacy, you will need to contact that pharmacy to set up an account with them. You can complete this step in one of the following methods:
 - a. Set up a profile on their website.
 - b. Call their customer service number
2. Have a list of the medications and prescribing doctors ready to input when asked.
3. Provide the pharmacy with your TrueScripts Processing information:
 - a. RxBin: 017274
 - b. RxPCN: PDMI
 - c. RxGroup: 99993996
 - d. Your Member ID number printed on your card
4. If you have current refills at another pharmacy, you can request that the mail order pharmacy call and request that they be transferred over to your new pharmacy.
5. A new prescription may be needed from your healthcare provider for 90-day fills at the retail pharmacy or mail order. The pharmacy can reach out to your provider to request this script. Since your provider should be able to call this into your pharmacy of choice, an office visit typically will not be required.
6. If the pharmacy informs you that your insurance is not contracted with TrueScripts, please request for them to call us so that we may further assist.

Mail Order Pharmacy Network

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343 Mercer Road
Greenville, PA 16125
PHONE: 844-522-CARE (2273) FAX: 844-308-1485
E-Scribe: NCPDP 6005943
carefillltc.com

***See note below**



7835 Freedom Ave NW
North Canton, OH 44720
PHONE: 1-866-909-5170 FAX: 1-866-909-5171
E-Scribe: NCPDP 3677361
envisionpharmacies.com/Mail/Patients



by pharmacy
250 Commercial Street, Suite 2012
Manchester, NH 03101
PHONE: 1-866-332-1668 FAX: 603-935-9108
E-Scribe: NCPDP 3061582
pillpack.com

***Dispenses 30-day supply only**



P.O. Box 2718
Portland, OR 97208
PHONE: 1-800-552-6694 FAX: 1-800-723-9023
NABP 3812674 – NPI 1528003910
ppsr.com

**Care-Fill mail order services are only available in the following states: AK, AZ, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KY, MI, MA, MO, MT, NJ, NM, NY, NC, ND, OH, PA, RI, SC, SD, VT, VA, WA, WI, WY.*

Maximize Your Savings

By Considering These Best Practices

90 Day Supply / Retail Pharmacy: To help cut costs and increase convenience to **you**, TrueScripts allows 90-day prescriptions to be filled at retail pharmacies nationwide. To obtain a 90-day prescription, have your prescribing provider call into your pharmacy of choice with the updated prescription; an office visit is typically not required.

Generic Medications: Generic medications provide quality, cost-effective alternatives to brand medications. Generic equivalents work the same way in the body and have the same ingredients, strength, dosage, and form as their brand-name counterparts. Unless otherwise directed by your doctor, it is a good idea to use generic equivalents when possible.

Over-the-Counter (OTC) Products: Some brand-name prescription drugs have OTC alternatives that are therapeutically identical and are likely a much lower cost option for treating your condition. When talking to your prescriber, ask if an OTC product is available. TrueScripts will also do our part to identify situations where OTC coverage will benefit both you and your health plan.

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Putnam County School Consortium

Prescription Benefits Guide
PPO

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Follow Us!



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www.twitter.com/TrueScriptsPBM



www.linkedin.com/company/TrueScripts

Putnam County School Consortium

Prescription Benefits At-A-Glance: PPO

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Preferred Brand	\$40	\$80
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Specialty	\$60	Not Available

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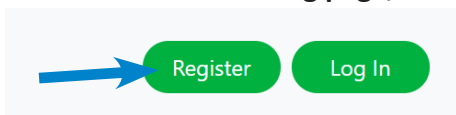
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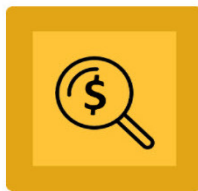
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Free Brand Name Medications for Putnam County Schools Members

Covered Employees and Dependents:

Putnam Schools has partnered with **RxProtect** to lower your pharmacy costs. This is a voluntary program; however, we strongly encourage you to enroll into the program if taking one or more of the eligible medications. **You can save money and get your prescriptions for free (no copays, deductible, or coinsurance) by using RxProtect.**

The medications provided through the RxProtect program are supplied and distributed through Health Canada Approved Distributors. Health Canada allows only the world's most respected medication distributors and suppliers to provide medications and adheres to stringent regulations similar to those of the FDA in the United States for the approval and dispensation of medications.

There are many medications under this program. Below is a list of *common* medications. If you do not see your medication listed, reach out to RxProtect to inquire.

AIMOVIG	HUMALOG	STEGLATRO
BASAGLAR	JANUMET	STELARA
BREO	JANUVIA	TOTALS
DOVATO	JARDIANCE	TRESIBA
ELIQUIS	LINZESS	TRULICITY
FARXIGA	OZEMPIC	XIGDUO
GILENYA	SOLIQUA	XIIDRA

RxProtect will work with your Rx Plan with TrueScripts to confirm the medication is covered under the Plan and status of any applicable Prior Authorizations for your scripts.

To enroll in the **RxProtect** program visit <https://www.rx-protect.com/putnamcountyschool/> to learn more or click [HERE](#).

Upon enrollment:

- Your monthly co-pays and payments toward your deductible are eliminated
- The medication will be delivered to your doorstep or shipping address of your choice
- You will have direct access to a pharmacist as needed
- You will need to have a current prescription, simply call your prescribing physician, and ask for the script to be faxed to (917) 909-5923, Attn: RxProtect, 9520 Ormsby Station Rd, Louisville Kentucky 40223
- RxProtect will work with your Rx Plan with TrueScripts to confirm the medication is covered under the Plan and status of any applicable Prior Authorizations for your scripts.

Please allow 2-3 weeks to receive the first fulfillment of your medication. Refills will be provided with no delay in shipping.

Contact RxProtect with all questions:

Email your dedicated nurse: nola.hughes@rx-protect.com

Phone: 1-833-279-7877

Internal Use



Prescription Program

Effective Date: January 1, 2022

INTRODUCTION

Putnam County Insurance School Group (the “Employer”) sponsors the **Putnam County Schools** (the “Plan”).

The Plan has two components: (1) this document which describes the prescription benefits available through the Plan (“Rx Program”); and (2) the medical component administered by **Medical Mutual of Ohio (MMO)** (“Medical Component Plan”). Prescription benefits provided under the Rx Program are described in this document and are exclusively provided under and subject to the terms of this document, except as specifically provided herein. The Rx Plan is considered a separate Rx plan for each school corporation that is part of the Putnam County Insurance School Group, subject to the terms of the Putnam County Insurance School Group. Non-prescription medical benefits are available under the Medical Component Plan.

Under no circumstance shall benefits be covered under both the Rx Program and the Medical Component Plan.

This document and the Medical Component Plan are deemed to be the plan document and summary plan description. For purposes of simplicity, this document incorporates by reference the following provisions from the Medical Component Plan: Eligibility; enrollment and termination of coverage; coordination of benefit provisions; HIPAA Privacy and Security Rules; the appeal procedures (except as modified herein); COBRA continuation of coverage; subrogation and reimbursement rights; exclusions and limitations and ERISA information and rights; all of which shall be deemed to be fully set forth herein.

RETAIL PHARMACY

As a Participant in the Medical Component Plan, you are eligible for prescription benefits under the Rx Program. Your eligibility for benefits under the Rx Program ends on the date your coverage ends under the Medical Component Plan.

The Rx Program uses a network of preferred pharmacies (“Participating Providers”) that have contracted with the Rx Program to charge Participants reduced fees for covered prescription drugs. In addition, certain drugs must be purchased at designated pharmacies. TrueScripts Managements Services, LLC (“TrueScripts”) provides claims processing and ministerial services for the Rx Program (but is not an insurer).

Any reimbursement by the Rx Program is determined per prescription (“Script”) by the reimbursement levels described herein, which is applied to each covered drug charge and is shown on the Schedule of Benefits. Scripts that exceed the identified per script annual limit will be excluded and not considered eligible expenses under the Plan or this Rx Program.

If a drug is purchased from a nonparticipating pharmacy or a Participating Pharmacy when the covered Participant’s ID card is not used, the Participant must pay the entire cost of the prescription, including copay, and then submit the receipt for direct reimbursement to TrueScripts at 513 E. South St., Washington, IN 47501 or www.truescripts.com, subject to the terms of the Rx Program.

PARTICIPATING PHARMACY

The Rx Program has a network of participating retail pharmacies. You can find a local retail pharmacy by visiting www.TrueScripts.com and navigating to the Pharmacy Locator section or by calling TrueScripts at (844) 257-1955. Participating Providers will change, so you should check the above website or contact

TrueScripts at the above phone number prior to obtaining pharmacy services or products.

DESIGNATED PHARMACY

If you require certain prescription drugs, TrueScripts may direct you to a designated pharmacy with which it has an arrangement to provide those prescription drugs. These drugs are listed on the formulary that can be found at www.truescripts.com or by calling TrueScripts at (844) 257-1955.

REIMBURSEMENT LEVELS

Benefits for eligible drugs are available for prescription drugs that are considered a covered expense as set forth in this document. The Rx Program pays benefits at different levels based upon prescription drug tiers as described below, subject to other exclusions described later in this summary. All prescription drugs covered by the Rx Program are categorized into these tiers on the Preferred Drug Formulary (PDF). The tier status of a prescription drug can change periodically, as frequently as monthly, based on TrueScripts' PDF Management Committee's periodic tier decisions. When that occurs, you may pay more or less for a prescription drug, depending on its tier assignment. Since the PDF may change periodically, for the most current information, call TrueScripts at (844)-257-1955. See the separate section below for Specialty Drugs.

Each tier is assigned a reimbursement level which is the amount the Rx Program pays. You will also pay a copay/coinsurance when you visit the Pharmacy. As an example, here is how the tier system works with 3 tiers:

1. Generic Tier is the lowest copay. For the lowest out-of-pocket expense, you should consider Generic Drug Tier drugs if you and your prescriber decide they are appropriate for your treatment.
2. Preferred Brand Tier is your middle copay. Consider a Preferred Brand Tier drug if no Generic Tier drug is available to treat your condition.
3. Non-Preferred Brand Tier if applicable is your highest copay. The drugs in Non-Preferred Brand Tier are usually costlier. Sometimes there are alternatives available in the Generic Tier or Preferred Brand Tier.

You are responsible for your deductible, if any, and paying the lowest of:

1. The applicable copay.
2. The network pharmacy's Usual and Customary Charge for the prescription drug; or
3. The prescription drug charge that TrueScripts agreed to pay the network pharmacy.

Pharmacy benefits apply only if your prescription is for an eligible expense. For excluded charges, you are responsible for paying 100% of the cost, and those charges do not count towards deductibles or maximum out of pocket. Amounts more than the Rx Program's specialty drug per script maximum are excluded. TrueScripts will assist Participants seeking reimbursement from third party resources but makes no guarantees.

Other programs or services, which may reduce a Participant's copay as outlined below, may be implemented by the Plan Administrator or procedurally changed by TrueScripts if, in their discretion and management of the plan, the program or service will benefit the Plan and participant and there is a likelihood that Plan and/or Participant expenses will be reduced over the longer term. Please see the Exclusion Section regarding the

treatment of drugs for which manufacturers provide rebates, discounts, or other payment methods.

The Plan Sponsor may offer multiple levels of formularies (referred to as “Level 1,” “Level 2,” etc.). If a Plan Sponsor adopts a multiple level formulary, Participants will be automatically enrolled for benefits under the Level I Formulary, the terms of which are described herein. Upon request or if TrueScripts believes it is beneficial, a Participant will be provided information regarding the other Level(s), including enrollment opportunities, the amount of the premium equivalent a Participant will pay for enrolling in the enhanced Level(s), and other terms of such Level(s). This information is also available by calling TrueScripts at (844)-257-1955.

SCHEDULE OF BENEFITS PER PERSON

Plan Name: HDHP/HSA Family

Co-Insurance	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Generic	100% until deductible met / \$15.00 after deductible met	100% until deductible met / \$30.00 after deductible met
Brand Preferred	100% until deductible met / \$40.00 after deductible met	100% until deductible met / \$80.00 after deductible met
Brand Non-Preferred	100% until deductible met / \$60.00 after deductible met	100% until deductible met / \$120.00 after deductible met

SPECIALTY	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Specialty Tier 1	100% until deductible met / \$60.00 after deductible met	Not Covered
Specialty Tier 2	20% to \$550.00 maximum	Not Covered
Specialty Tier 3	20% to \$2,000.00 maximum	Not Covered
Specialty Tier 4	20%	Not Covered
Specialty Tier 5	50%	Not Covered

Deductible	RX & Medical Combined / Individual \$5,000.00 / Family \$5,000.00
Max Out of Pocket	RX & Medical Combined / Individual \$7,000.00 / Family \$7,000.00

- Family Deductible and Family Max OOP are not embedded. If group health plan is intended to be a high deductible health Plan (HDHP), benefits will be processed to maintain HSA eligibility.

Plan Name: HDHP/HSA Single

Co-Insurance	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Generic	100% until deductible met / \$15.00 after deductible met	100% until deductible met / \$30.00 after deductible met
Brand Preferred	100% until deductible met / \$40.00 after deductible met	100% until deductible met / \$80.00 after deductible met
Brand Non-Preferred	100% until deductible met / \$60.00 after deductible met	100% until deductible met / \$120.00 after deductible met

SPECIALTY	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Specialty Tier 1	100% until deductible met / \$60.00 after deductible met	Not Covered
Specialty Tier 2	20% to \$550.00 maximum	Not Covered
Specialty Tier 3	20% to \$2,000.00 maximum	Not Covered
Specialty Tier 4	20%	Not Covered
Specialty Tier 5	50%	Not Covered

Deductible	RX & Medical Combined / Individual \$2,500.00 / Family \$2,500.00
Max Out of Pocket	RX & Medical Combined / Individual \$3,500.00 / Family \$3,500.00

- Family Deductible and Family Max OOP are not embedded. If group health plan is intended to be a high deductible health Plan (HDHP), benefits will be processed to maintain HSA eligibility.

Plan Name: PPO

Copay	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Generic	\$15.00	\$30.00
Brand Preferred	\$40.00	\$80.00
Brand Non-Preferred	\$60.00	\$120.00

SPECIALTY	1 - 30 DAY SUPPLY	31 - 90 DAY SUPPLY
Specialty Tier 1	\$60.00	Not Covered
Specialty Tier 2	20% to \$550.00 maximum	Not Covered
Specialty Tier 3	20% to \$2,000.00 maximum	Not Covered
Specialty Tier 4	20%	Not Covered
Specialty Tier 5	50%	Not Covered

Deductible	N/A
Max Out of Pocket	RX & Medical Combined / Individual \$8,700.00 / Family \$17,400.00

- Family Max OOP is embedded.

The portion of a covered expense that is actually paid by the Participant will apply towards deductibles and coinsurance under Medical Component Plan only if you enroll in the Integrated Medical Component Plan. Deductibles, coinsurance, and co-pays apply towards **applicable** out of pocket limits.

SPECIALTY PHARMACY SCHEDULE OF BENEFITS PER PERSON

“Specialty Drugs” are medication that share one or more of the following characteristics:

- 1) Prescribed for a person with a complex or chronic medical condition,
- 2) Treats rare or orphan disease diagnoses,
- 3) Requires additional patient education, assessment, adherence, and support,
- 4) Can be difficult to administer,
- 5) Is an oral, injectable, inhalable, or infusible medication,

- 6) Has unique shipment or storage, or other special handling requirements,
- 7) Is usually supplied by a limited pharmacy network,
- 8) High cost per fill.

A prior authorization is required for all Specialty Drugs, a list of which can be obtained by calling TrueScripts at (844) 257-1955. First time dispensing of a Specialty Drug may be limited to less than a 30-day supply when not prepackaged for a larger quantity. Additionally, a maximum unit of measure quantity limit per person/plan year may apply to some Specialty Drugs. Covered prescription injectable(s) and certain other specialty drugs such as chemotherapies may only be available through a designated specialty pharmacy. Specialty Drugs are categorized into the above Copay Tiers under Schedule of Benefits or as determined by TrueScripts' PDF Management Committee.

For specialty drug maximum unit of measure quantity limit coverage per person/calendar year and Specialty Drugs available through the Specialty Pharmacy contact TrueScripts Member Care Team at (844)-257-1955. Further, some Specialty Drugs may be excluded from a formulary Level. A Participant who is prescribed a Specialty Drug should contact TrueScripts Member Care at the above phone number to determine if the Specialty Drug is excluded from the Participant's Formulary Level and to determine if other Formulary Levels are available to the Participant that cover the Specialty Drug.

DIRECT PARTICIPANT REIMBURSEMENT

In order for a request for reimbursement to be processed, a Participant must complete a prescription drug claim form, obtained from the Employer or at www.truescripts.com, attach the receipt, and submit it to TrueScripts at the following address:

TrueScripts Management Services
513 E. South St.
Washington, IN 47501
Attn: Claims Department

A Participant will be reimbursed the amount he/she paid to the pharmacy subject to the terms set forth in the Plan and this Rx Program.

CLINICAL TRIAL COVERAGE

Benefits for clinical trial coverage under this Rx Program will be administered consistently with the requirements of the Affordable Care Act. Please see the Medical Component Plan document for terms related to clinical trials.

LIMITATION OF PHARMACY SELECTION

If TrueScripts determines that you may be using prescription drugs in a harmful or abusive manner, or with harmful frequency, your selection of network pharmacies may be limited. If this happens, you may be required to select a single network pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single network pharmacy, subject to the terms of this Rx Program.

SUPPLY LIMITS

Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. Additionally, a maximum unit of measure quantity limit per person/plan year may apply to Specialty Drugs. To determine if a prescription drug has been assigned a supply limit or maximum unit of measure quantity limit per person/plan year for dispensing call TrueScripts at (844)-257-1955. Whether or not a prescription drug has a supply limit or maximum unit of measure quantity limit coverage per person/calendar year is subject to TrueScripts' periodic review and modification.

Any one retail non-specialty prescription is limited to a ninety (90) day supply and any authorized refills, per Script.

"DISPENSED AS WRITTEN" DRUG PROVISION

The Rx Program requires that retail pharmacies dispense generic when available unless the prescriber specifically prescribes a brand name drug and marks the prescription "dispense as written." "Dispense as Written" prescriptions may require a Prior Authorization.

Should a Participant choose a Brand name drug, rather than the generic equivalent when the prescriber does not indicate Dispense as Written, the Participant will be responsible for the applicable Brand name drug copay plus the cost difference between the Brand and generic drugs. Additionally, only the applicable generic copay the Participant would have paid will apply toward the Participant's deductible and / or out-of-pocket maximum.

PRESCRIPTION DRUGS LOST AS A DIRECT RESULT OF A NATURAL DISASTER

Participants will be given the opportunity to prove that prescription drugs otherwise considered covered expenses under this plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

COVERED EXPENSES

The following are prescription products considered covered expenses under the Rx Program:

1. Medications that are necessary for the care and treatment of an illness or injury and are prescribed by a duly licensed medical professional; and
2. Medications which can be obtained only by prescription and dispensed in a container labeled "Rx Only;"
3. The following non-prescription (OTC) drugs prescribed by a duly licensed medical professional:
 - a. Medications or vitamins as required by the Affordable Care Act, and
 - b. In an amount not to exceed the day's supply outlined in the prescription schedule of benefits.
 - c. All other non-prescription OTC drugs that are included in the Medical Component Plan document.
4. Medications for medical treatment or prescription coverage not otherwise excluded by the Medical Component Plan or this Rx Program.
5. Covered medications prescribed and filled while the Participant is a Participant in this Rx Program.

Covered expenses under the Rx Program include Adjudication fees, Prior Authorization fees, and Specialty Care fees and expenses.

LIMITS AND EXCLUSIONS

The Rx Program's prescription drug benefits apply only when a Participant incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a prescriber.
2. Refills up to one year from the date of order by a prescriber.

In addition to exclusions in the Medical Component Plan document, the following exclusions apply. One or more exclusions may apply to any prescription.

When exclusions apply to only certain prescription drugs, you can call TrueScripts at (844) 257-1955 for information about which prescription drugs are excluded. Excluded medications include:

1. Medications for any condition, injury, sickness, or mental health disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received under any workers' compensation law or other similar laws,
2. Any prescription drug for which payment or benefits are covered or available as primary from the local, state, or federal government (for example Medicare), whether or not payment or benefits are received, except as otherwise provided by law,
3. Medications available over the counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the plan has designated over-the-counter medication as eligible for coverage as if it were a prescription drug and it is obtained with a prescription order or refill from a prescriber,
4. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill,
5. Compounded drugs that are available as a similar commercially available prescription drug,
6. Medications dispensed outside of the United States, except in an emergency and except for International Importation Medications as approved for by the Plan,
7. Durable medical equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered in the Schedule of Benefits),
8. The amount dispensed (days' supply or quantity limit) which exceeds the applicable supply limit,
9. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit,
10. Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the TrueScripts PDF Management Committee, a list of which may be obtained by calling TrueScripts at (844) 257-1955.
11. Medications prescribed, dispensed, or intended for use during an inpatient stay,
12. Prescription drugs, including new prescription drugs or new dosage forms, that do not meet the definition of a covered expense,
13. Medications used for conditions and/or at dosages determined to be experimental or investigational, or unproven, unless TrueScripts or the Plan have agreed to cover an experimental or investigational or unproven treatment,
14. If a drug manufacturer or third party provides for rebates, discounts, and/or reimbursement of all or a portion of the medication supply, that supply portion may be excluded under the terms of the Rx Program. Manufacturer and third-party payment programs do change, and information about this exclusion may be obtained by calling TrueScripts. If a Participant is eligible for a rebate, discount, or reimbursement from a manufacturer or third party, and does not apply for this

rebate, discount, or reimbursement, the number of Scripts associated with that rebate, discount, and/or reimbursement will be excluded unless/until the Participant completes and submits an Affidavit establishing that the Participant did not apply and stating the reason(s) for the failure to apply or provides evidence that any application for such rebate, discount, and/or reimbursement was denied,

15. All exclusions and limitations under the Medical Component Plan, and
16. In accordance with the preferred formulary and procedures implemented by TrueScripts, as modified from time to time, certain prescriptions will be deemed processed under the Major-Medical portion of the Medical Component Plan, and therefore excluded under the prescription program. All other prescriptions covered by the Rx Program are excluded by the Major-Medical provisions of the Medical Component Plan.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

The following amounts do not accrue towards the total covered expenses that are the responsibility of the Participant and do not accumulate toward the applicable Deductible and/or Out-of-Pocket Maximum:

1. Premiums,
2. Expenses that are excluded under the Rx Program,
3. Expenses in excess of the reasonable and customary charges for services or supplies,
4. Expenses in excess of any maximum quantity list in the Rx Program,
5. Penalties,
6. Expenses reimbursed, waived, or covered through manufacturer or third-party assistance programs or discount programs,
7. Expenses for brand-name drugs above the applicable generic copay the Participant would have paid as outlined in the "Dispensed as Written Drug Provision.", and/or
8. Any cost related to a drug that is partially or wholly excluded.

PRIOR AUTHORIZATION REQUIREMENT

TrueScripts has been retained by the Plan Administrator to provide Prior Authorization services for a particular set of drugs. The Plan has approved a predetermined set of criteria to be applied to this Prior Authorization process. For a drug which is subject to Prior Authorization to be covered by this Rx Program; the pharmacist, Participant, or prescriber must call the TrueScripts Customer Care Department to obtain Prior Authorization before the drug is purchased. TrueScripts will fax the prescriber the necessary forms to obtain the information necessary to determine whether the drug will be a covered expense, based upon the predetermined set of criteria and the information supplied by the prescriber. TrueScripts will notify the pharmacy/Participant or prescriber who submitted the request for Prior Authorization within 72 hours (once the letter of medical necessity is received from the prescriber) that the drug is or is not covered by the Plan. The request for Prior Authorization is considered to be a pre-service claim as described in the U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000). TrueScripts authorization is not a guarantee that the drug is eligible for payment under the Rx Program or Plan.

The Rx Program may include a Step Therapy program which promotes the utilization of certain Preferred Drugs in specific drug categories such as cholesterol lowering statins and proton pump inhibitors (gastro-intestinal agents); however, others may be identified. Certain drugs have been identified which will not be covered under the Rx Program if the Step Therapy program has not been followed and a Prior Authorization obtained. The Step Therapy program requires documentation from a prescriber that the Participant has tried a minimum number of alternative drug treatments and that they did not successfully treat the Participant's

condition. If a medication the Participant is taking is identified as a Step Therapy drug, the Participant is not required to change medications, but it will not be covered under the Rx Program unless approved through TrueScripts. For more Information on this Step Therapy program, please contact TrueScripts at (844) 257-1955 or visit www.truescripts.com.

For a list of drugs that require prior authorization, please visit www.truescripts.com or by calling (844) 257-1955.

APPEALING A DENIED CLAIM OR PRIOR AUTHORIZATION

Procedures to appeal denial of claims, services or pre-authorization requests are set forth in the Medical Component Plan and are deemed incorporated herein. However, all appeals for Rx Program shall be sent to and administered by:

TrueScripts Management Services, LLC, C/O Appeals Dept.,
513 E. South St.,
Washington, IN 47501.

TrueScripts has the discretionary authority to determine the right to benefits and any appeals under the Rx Program.

EMERGENCY SUPPLY

For covered medications and in instances in which a Prior Authorization cannot be immediately obtained, Participants may receive and be reimbursed for up to a 72-hour supply of a covered outpatient drug as an “emergency supply.” Such emergency supply must be obtained in accordance with the Rx Program.

PREVENTIVE CARE SCHEDULE OF BENEFITS PER PERSON PER CALENDAR YEAR

The Plan routinely covers exams and screenings that prevent and identify early certain medical conditions. In accordance with the Affordable Care Act, the Rx Program covers services for preventive care at 100%.

Contraceptive Preventive Care

The Rx Program will cover certain contraceptive preventive care prescriptions or devices for women without cost sharing. Coverage without cost sharing means women can receive the prescriptions or devices without having to pay a deductible, coinsurance, or copayment.

There are some contraceptive prescriptions for which Participants will have to pay a deductible, copayment, or coinsurance. To minimize your out-of-pocket pharmacy costs, follow the below guidelines for prescriptions that will be covered with no cost sharing.

The Rx Program benefits cover female contraceptive prescriptions with no cost sharing for Participants receiving these drugs or devices for the prevention of pregnancy that are:

1. Prescribed by a prescriber,
2. Generic,
3. Brand-name drugs without a generic or therapeutic equivalent, and
4. Obtained from an in-network pharmacy.

The Rx Program will also cover brand name drugs where a generic is available with no cost sharing if approved thru the TrueScripts Prior Authorization process. Contraceptives not included in the above will be covered at the applicable Participant's cost share.

Additional Preventive Care

Additional preventive prescription drug benefits covered according to the Affordable Care Act include the following if:

1. Prescribed by a licensed prescriber,
2. Are generic,
3. Are brand-name drugs without a generic equivalent, and
4. Are obtained from an in-network pharmacy:

Aspirin	Quantity Limit: 1/day	Aspirin products up to 325mg	
Bowel prep medications	Age limit 45-75 years of age	All prescription products, including OTCs if processed as a prescription. Brand name will be covered only if it doesn't have a generic.	Clenpiq, Gavilyte, Gialax Kit, Goyltely, Moviprep, Nulytely, Osmoprep, PEG 3350, Peg-Prep, Plenvu, Suprep.
Fluoride - Chemoprevention of dental cavities	Age limit ≤ 6 years of age	Sodium fluoride products only, not in combination. · Sodium fluoride tab 0.5mg – 1mg · Sodium fluoride chew tab 0.25mg – 0.5mg · Sodium fluoride solution	· Sodium fluoride tab 0.5mg – 1mg · Sodium fluoride chew tab 0.25mg – 0.5mg · Sodium fluoride solution
Folic Acid - Supplementation with folic acid	Women planning or capable of pregnancy Quantity limit: 1/day	Folic acid products only, not in combination.	· Folic Acid tab 0.4mg and 0.8mg.
Vitamin D for fall prevention	Age limit ≥ 65 years of age	Vitamin D	
Statins	Age limit 40-75 years	All generic statin products in low to moderate doses, plus additional doses of generic statin products to the extent determined preventive by the Plan Administrator.	Atorvastatin 10mg, 20mg. Fluvastatin 20mg, 40mg. Lovastatin 10mg, 20mg. Rosuvastatin 5mg, 10mg. Pravastatin 10mg, 20mg. Simvastatin 5mg, 10mg, 20mg.
Breast Cancer	Females only, ages ≥ 35 years of age	Prescribed chemoprevention medications for women at increased risk of breast cancer.	Anastrozole 1mg, Exemestane 25mg, Raloxifene 60mg, and Tamoxifen 10mg, 20mg.
Iron supplements	Age limit 6 to 12 months at risk for anemia	All dosage forms covered.	

PrEP	PrEP diagnosis only	Generic Truvada	Emtricitabine and Tenofovir disoproxil fumarate 200mg/300mg (generic Truvada).
Immunizations	Any prescribed vaccination administered at a pharmacy.	Age limit \geq 50 years of age for Shingrix and Zostavax	
Tobacco Cessation	Up to a 90-day supply of prescribed tobacco cessation drugs two times in 365 calendar days.	The prescriber must prescribe all smoking cessation products for use within the 12-week treatment time frame.	Nicotine patches, gum, lozenges. Chantix (may require Step Therapy).

Other Terms

The Plan Administrator may approve certain charges or expenses that are otherwise excluded if it determines, in its sole discretion, that the Plan and participant will benefit, and there is a likelihood that Plan expenses will be reduced over the longer term. If third party funding, discount, or rebate is available, TrueScripts may allocate up to the total amount available proportionately over the remaining calendar months in the Plan Year and treat such proportionate amount as an excluded expense in each respective month.

When Participation Begins

Upon enrollment in the Medical Component Plan, you will be able to access prescription benefits under the Rx Program.

When Your Participation Ends

Your participation in the Rx Program ends on the date you are no longer covered under the Medical Component Plan.

MISCELLANEOUS

General

1. The Employer reserves the right to amend, modify, or terminate the Rx Program.
2. Neither the Employer nor the service providers guarantee the tax consequences of any reimbursements under this Rx Program.
3. Expenses which you claim as deductions or credits on your Federal Income Tax Return cannot be reimbursed under the Rx Program.

Oral Statements

No oral statement of any person shall:

1. Modify or otherwise affect the benefits, limitations, or exclusions of the Rx Program,
2. Convey or void any coverage,
3. Increase or reduce any benefits of the Rx Program, or
4. Be used in the prosecution or defense of a claim under the Rx Program.

Plan is not Worker's Compensation Insurance

The coverage provided under the Rx Program does not replace, supplement, or provide a substitute for benefits to which you are entitled under worker's compensation; occupational disease; and similar laws.

The Rx Program does not cover health services or expenses, directly or indirectly, related to such services that are provided or payable under worker's compensation, occupational disease, and similar laws:

1. Even if you or the Employer are/is not properly insured or self-insured under such laws,
2. When you refuse to use your or the Employer's designated prescriber, or
3. When you have not abided by the Employer's policy for treatment or reporting of a work-related illness/injury.

Anti-Assignment

No Participant, beneficiary, or any other person such as a guardian, shall have the right to assign, transfer, alienate, mortgage, pledge, or otherwise encumber any benefit or right provided under the Rx Program, or any benefit or right provided by ERISA related to the Rx Program. This includes, but is not limited to, the right to file claims or appeals, request information, and the right to bring a lawsuit seeking benefits, penalties, damages, or equitable relief. Any such attempted disposition thereof shall be void. Benefits will not be subject to attachment, garnishment, execution, or levy of any kind.

Notwithstanding the foregoing, this provision will not prevent direct payments to third party medical providers for the convenience of the Rx Program, the member, or claims administrator. The Plan Administrator reserves the discretionary authority to determine the validity of any arrangement to direct the payment of benefits to a third party and does not guarantee that any arrangement will be valid under the Rx Program. Any payment to a third party shall not be construed to give such party any rights under the Rx Program, including any right to receive future payments or ERISA rights.

Plan Sponsor

____ / ____ / ____

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Your EAP Benefit Summary

*Each of us encounters personal problems from time to time. And that is why we partner with ESI EAP to provide you with the best possible solutions for issues you or one of your family members may face. **Your EAP is here to help.***

The following free benefits are available for Employees and Family Members.

> COUNSELING BENEFITS

Help from experienced Masters or Ph.D. level counselors for personal issues such as: relationships/family, depression/anxiety, grief and more.

> PEAK PERFORMANCE COACHING

Personal and professional coaching is available from senior-level ESI coaches. Get one-to-one telephonic coaching and support, as well as online self-help resources and trainings.

> TRAINING AND PERSONAL DEVELOPMENT BENEFITS

Over 10,000 free online personal and professional development trainings in a variety of easy to use formats. Some of the topics covered are: debt, budgeting, communication, working remotely, stress management and emotional intelligence.

> SELF-HELP RESOURCES

Self-help Resources give you access to a collection of thousands of tools, videos, financial calculators and informative articles covering virtually every issue you might face, including adoption, relationships, legal, financial, cancer and more.

> WORK/LIFE BENEFITS

Assistance for financial, legal, and child & elder care.

> PERSONAL ASSISTANT

Help for everyday issues, including finding a local medical or dental provider, summer camp options and more.

> WELLNESS BENEFITS

Videos and resources to improve you and your family's overall health, including fitness, diet and tobacco cessation.

> LIFESTYLE SAVINGS BENEFIT

Includes thousands of discounts, rewards and perks in a variety of categories: Health & Wellness, Auto, Electronics, Apparel, Restaurants, Beauty & Spa, Flowers & Gifts, Sports & Fitness and more! Available benefits are accessible from ESI's Member website.

Scan the QR code to explore your EAP benefits!



Contact the EAP toll-free at **1.800.252.4555**.

All calls are **CONFIDENTIAL** and answered by a Masters or Ph.D. level counselor; your counselor will work with you on a plan beginning with the first call. Or go to **www.EducatorsEAP.com** and create a username and password.



www.EducatorsEAP.com
1.800.252.4555

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ **See page 3** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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 us using the information on page 1.
- 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:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We 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.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

Appendix D

Payroll Items / Time
Sheets

Putnam County Educational Service Center
124 Putnam Parkway
Ottawa, OH 45875

Social Security # _____

Pay Period Ending _____

Employee Name _____

Position _____

PCESC Payroll Time Sheet

Day of Week	Date	Morning		Afternoon		Total Hours
		IN	OUT	IN	OUT	
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Weekly Total						

Day of Week	Date	Morning		Afternoon		Total Hours
		IN	OUT	IN	OUT	
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Weekly Total						
Bi-Weekly Total						

*At least a 30 minute lunch break must be taken when working 6 hours or more.

I certify the time stated above is accurate and truly reflects my work schedule.

Signature of Employee

Signature of Supervisor

Treasurer Office Use Only

Total Hours _____

Account # _____

Rate _____

Amount _____

County Superintendent's Signature

**Putnam County Educational Service Center
124 Putnam Parkway
Ottawa, Ohio 45875**

Classroom Location (Please circle one)

MH

Columbus Grove
Continental
Ottawa Elementary
Ottawa-Glandorf HS
Pandora-Gilboa

ED

ESC Annex

Preschool

Columbus Grove
Continental
Fort Jennings
Leipsic
Miller City
Ottawa-Glandorf
HS

SUBSTITUTE TEACHER PAYROLL FORM

Substitute Name: _____ SSN#: _____

Address: _____

Phone Number: _____

Please complete one form per site worked and return to the Putnam County ESC.

Week Day	Date	Substituted For	In	Out	Lunch	In	Out	Total Hours
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

Total Hours: _____

I certify the time stated above is accurate and truly reflects my work schedule.

Substitute Signature

Date

School District Representative

Date

.....

TREASURER OFFICE USE ONLY

Total Days: _____


Rate: _____

Account # _____



Amount: _____

County Superintendent Signature

Print clearly and fill out all sections. An incorrect timesheet may cause a delay in pay. Please send timesheet no later than **Monday at 8:30AM to Putnam County ESC (419) 523-6126 or pm payroll@putnamcountyesc.org**

<div><div>Dedicated School Staffing 6546 Weatherfield Court Building B, Suite 1 Maumee, OH 43537 P: 419-725-9499</div></div>	<div>EMPLOYEE MUST SIGN THIS FORM I certify that I worked the hours reported on this ticket during the week shown and I did not experience any accident or injury that I did not report directly to Dedicated School Staffing.</div> <div><div>PC ESC</div><div>POSITION TITLE Sub Aide (SERS)</div><div>PROGRAM NAME</div><div>EMPLOYEE NAME</div><div>SIGNATURE</div></div>																																																						
<div>Show all hours to nearest quarter hour (i.e. 0.25; 0.50; 0.75)</div> <table><thead><tr><th>DATE</th><th>DAY</th><th>TIME IN</th><th>TIME OUT</th><th>LESS LUNCH</th><th>TOTAL HOURS</th></tr></thead><tbody><tr><td></td><td>MON.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>TUES.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>WED.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>THURS.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>FRI.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>SAT.</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>SUN.</td><td></td><td></td><td></td><td></td></tr><tr><td colspan="5">TOTAL HOURS FOR WEEK:</td><td></td></tr></tbody></table>		DATE	DAY	TIME IN	TIME OUT	LESS LUNCH	TOTAL HOURS		MON.						TUES.						WED.						THURS.						FRI.						SAT.						SUN.					TOTAL HOURS FOR WEEK:					
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<p>The Client Representative signature below certifies that: (1) the hours shown are correct, (2) the work was performed in a satisfactory manner, (3) there was no known injury to a Dedicated School Staffing employee that was not reported to Dedicated School Staffing, and (4) Dedicated School Staffing is authorized to bill Client by the terms of the Service Order Confirmation for the work performed by the named employee. It is agreed that timesheets submitted by facsimile transmission are valid for billing purposes. By signing below, the Client Representative confirms that he/she is authorized to approve time and that Dedicated School Staffing may rely upon his/her signature as binding upon Client.</p>	<p>POSITION TITLE _____</p> <p>PROGRAM NAME _____</p> <p>EMPLOYEE NAME _____</p> <p>SIGNATURE _____</p>																																																	
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SUPERVISOR NAME

SUPERVISOR SIGNATURE

NAME OF SCHOOL BUILDING

Putnam Co Educational Service Center

NOTES

Collective Bargaining Agreement

between the

**Putnam County Education
Association**

and the

**Putnam County Educational
Service Center
Governing Board**

July 1, 2021 through June 30, 2024

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COLLECTIVE BARGAINING AGREEMENT

This Agreement is entered into by and between the Putnam County Educational Service Center Board of Education, hereinafter referred to as the "Board," and the Putnam County Education Association, OEA/NEA, hereinafter referred to as the "Association."

ARTICLE I - RECOGNITION

A. Association Recognition

This Agreement is entered into by and between the Putnam County Board of Education, hereinafter referred to as the "Board," and the Putnam County Education Association, OEA/NEA, hereinafter referred to as the "Association." The Board recognizes the Association as the sole and exclusive representative for the purpose of exercise of such rights as set forth in this Agreement and/or as defined and set forth in O.R.C. 4117 for all staff members in the employee bargaining unit as set forth in Section "B" herein.

B. Bargaining Unit

The bargaining unit shall include all full-time and part-time employees employed by the Board in a position requiring a four (4) year college degree and a teaching certificate/license issued by the Ohio Department of Education, and licensed speech/language therapists, who provide direct teaching and/or therapy services to students. The Superintendent, Treasurer, all administrators, all program supervisors and coordinators, all confidential employees, all casual and substitute employees, and all other employees shall be excluded from the bargaining unit.

ARTICLE 2 - ASSOCIATION RIGHTS

The Association shall be granted the following delineated sole and exclusive organizational rights as the agent of the bargaining unit.

A. Access to Buildings and Members to Conduct Association Business

Employees covered by this Agreement assigned to locations not under the control of the Board of Education of Putnam County shall have access to duly authorized representatives of the Association under the same rules as established for access to that local's bargaining unit membership in the respective building.

Such Association representatives may visit the Putnam County Board office for the purpose of meeting or conducting Association business with employees covered by this Agreement, provided that the appropriate administrator is notified in advance of the meeting, and provided that such visits do not occur on the work time of, or interfere with the normal work duties of an employee covered by this Agreement.

B. Use of Buildings and Equipment

1. Upon request and with the prior notice of the appropriate administrator, the Association may use the Putnam County Board offices for meetings and other business of the Association provided no other school-related activities are scheduled for the area and time requested, and provided further that the meeting in the building is concluded during the time the building is open to the public.

2. The Association shall have the right to use school word processing equipment such as typewriters and copy machines at reasonable times when such equipment is not

otherwise in use. The Association shall pay for the reasonable cost of all materials and supplies incident to such use. The Association shall be responsible for any damage to said equipment resulting from the Association's use.

C. Use of Bulletin Boards

The Association shall be permitted to display Association materials on a designated bulletin board.

D. Access to Board Meetings/Board Documents

The president of the Association shall be provided with a copy of the Board agenda and accompanying data regarded as public information no later than the day prior to a Board meeting. The president of the Association shall be placed on the Board agenda upon his/her request, provided the issue has first been discussed with the Superintendent. When Board meetings are held during normal working hours, the Superintendent will make arrangements so as to enable an Association representatives to be present. The Association shall be responsible for notifying the Superintendent as to who such representative will be.

Upon request, the Association shall be provided without cost one (1) copy of the following:

1. Board minutes;
2. Board policy manual;
3. Employee directory;
4. Budget and financial reports and documents when they are prepared.

E. New Staff

1. Names and addresses of newly-employed professional staff members shall be provided to the Association following Board approval of their contract.
2. At the first day orientation meeting, the Association will be provided the opportunity to address the staff following the close of the comments or address by the Superintendent and/or other administration.

F. Payroll Deduction of Association Dues

1. The Association shall be granted the right to payroll deduction for each Association member of his/her Association dues as annually authorized by that member, without cost to the Association and/or the member. The Association shall determine the amount to be deducted for each Association member and shall so notify the Board Treasurer of his/her designee by September 15.

Such authorization shall continue in effect until such time that said staff member gives written notice to the Treasurer of the Board to discontinue such deductions or employment with the Board terminates.

Such deduction(s) shall be made in equal amounts from each paycheck beginning with the last paycheck in September and continuing for each of the successive paychecks throughout the last paycheck in August or the last paycheck of the school year, whichever comes first.

2. All dues of the Association and its affiliates which are deducted from each member's paycheck shall be forwarded by the Board Treasurer or his/her designee to the Association Treasurer in a single check each month.

Within two (2) days of the receipt of a bargaining unit member's written notice to discontinue such deductions, the Board Treasurer shall provide the Association Treasurer a copy of such withdrawal of payroll authorization.

G. Association Leave

The president of the Association or his/her designee, or elected delegates to meetings of the Ohio Education Association, or other state and national organizations affiliated with same, may attend official meetings of these bodies which are required of them in their elected or appointed positions without loss of pay. No expenses for such meetings, shall be paid by the Board. The Association shall reimburse the Board for substitute service costs. Association leave shall be limited to a maximum of three (3) days per year.

H. No Reprisal Clause

There shall be no reprisals or penalties of any kind taken against or levied upon any professional staff member by reason of his/her membership in the association or participation in any of its activities.

ARTICLE 3 - NEGOTIATION PROCEDURES

A. Requests for Opening of Negotiations

Negotiations may be initiated not more than one hundred twenty (120) days prior to the expiration of the contract by notice from the Association to the Superintendent or by the Superintendent to the president or bargaining agent of the Association. Upon receipt of a request to begin negotiations, a mutually-convenient meeting date shall be scheduled. Both parties agree to conduct negotiations in good faith as that term has been interpreted by the laws of the State of Ohio through their designated representatives.

B. Negotiating Period

Commencing with the initial agenda setting session, negotiations will continue for a period of at least sixty (60) days exclusive of mediation or other impasse procedure, unless the parties mutually agree to extend the period for such negotiations.

C. Exchange of Information

The designated representatives of the Board and the Association agree to make available to each other upon written request and with a reasonable period of time all available public information on matters which are being negotiated.

D. Initial Negotiating Session/Subsequent Negotiating Session

At each and every negotiating session shall be the establishment of a mutually-agreeable time, date, and place of the next session between said teams.

The following provisions will generally govern the conduct of such meetings unless otherwise agreed by the parties:

1. All negotiations shall be conducted in executive sessions exclusively between said representatives unless the parties mutually agree to waive this provision.
2. All items negotiated to tentative agreement will be reduced to writing, dated, and initialed by the chairperson of each negotiating team.

E. Ratification of Agreement

When an agreement is reached by the negotiating teams, that agreement shall be reduced to writing and signed by the chairperson of each team. Each team will recommend favorably to its members the acceptance of the tentative agreement. The tentative agreement shall be submitted to the Association for possible ratification with the results of the ratification vote by the Association's membership communicated to the Board in writing by the president of the Association or his/her designee. Upon receipt of the notification that the Association has ratified the agreement, the Board shall meet to act on the tentative agreement at the next regular or special meeting of the Board of Education which shall be not more than fifteen (15) days after the submission of the tentative agreement to the parties.

F. Final Agreement

Following ratification by both the Association and the Board, four (4) copies of the Agreement shall be executed by the parties. Each of the parties shall retain a copy of the Agreement. One (1) copy shall be submitted to the State Employment Relations Board (hereinafter referred to as "SERB"), pursuant to its rules and one (1) copy shall be retained by the agent of record.

G. Impasse Procedure

1. Mutually Agreed Alternate Dispute Resolution Procedure:

The impasse resolution procedures herein shall supersede the dispute settlement procedures set forth under ORC 4117.14.

2. Responsibilities:

The parties pledge themselves to negotiate in good faith, and in the event of failure to reach agreement, to utilize in good faith such mediatory facilities as are or may be provided.

3. Mediation:

If agreement is not reached on matters being negotiated at the end of the negotiating period or not later than thirty (30) calendar days prior to the expiration date of this Agreement, either party may declare an impasse and request that an impartial mediator be appointed. The Federal Mediation and Conciliation Service shall be requested to appoint a mediator, and the selection shall be in accordance with the rules of the Federal Mediation and Conciliation Service.

In the event that the Federal Mediation and Conciliation Service makes a policy not to provide assistance to public school districts or is otherwise unable to provide services to the parties, either party or the parties jointly shall petition, in writing, the American Arbitration Association to provide a list of seven (7) names. If there are no names acceptable on this list to one of the two parties, that party may request a second list. The parties shall alternately strike a name until one remains, and that person shall serve as the mediator.

The mediator shall have the authority to schedule and conduct meetings for the purpose of assisting the parties to reach a settlement of the impasse.

Both parties hereby agree to give, upon request, such information as the mediator deems necessary.

Except by mutual written consent, the selection and mediation process shall not extend for more than thirty (30) calendar days from the date of the declaration of impasse. The parties shall be permitted to postpone or extend the mediation process by not more than fifteen (15) days and shall not extend beyond the expiration of this Agreement except by written agreement of the parties prior to such expiration. All such extensions shall be for a specified period of time. The cost of securing and utilizing the services of a mediator shall be shared equally by the Board and the Association.

ARTICLE 4 - GRIEVANCE PROCEDURE

A. Purpose

The purpose of this grievance procedure is to secure, at the lowest possible administrative level, the resolution of any dispute over the terms of this Agreement. Both parties agree that grievance proceedings shall be kept as informal and confidential as appropriate at all levels of the procedure. The parties further agree that this procedure shall be available to all employees covered by this Agreement, and no reprisals of any kind shall be taken against any employee initiating or participating in the grievance procedure.

B. Definitions

1. **Grievance** - a grievance is any complaint or dispute involving the interpretation, application or alleged violation of this Agreement.
2. **Grievant** - a grievance may be filed by the employee(s) affected by the action being grieved, or by the Association.
3. **Day** - day shall mean "working" day.
4. **Immediate or Appropriate Supervisor** - for purposes of the grievance procedure shall mean the lowest level administrator having the authority to resolve the grievance.

C. Step One

A grievance within the meaning of this Article shall be presented directly to the employee's immediate supervisor or other appropriate administrator within twenty-five (25) days of the occurrence of the event giving rise to the grievance. The grievance shall be submitted in writing, and the written grievance shall contain a statement of the alleged facts upon which the grievance is based and shall reference the specific provision(s) of this Agreement allegedly violated, misinterpreted or misapplied. The grievant may request a hearing before the supervisor at this level. If requested, the hearing shall be at a time mutually agreeable to the grievant and the supervisor. The supervisor shall respond to the grievance in writing within seven (7) days after receipt of said grievance, or if a hearing is requested, within seven (7) days after the conclusion of said hearing. The written response shall be sent to the grievant and the Association president.

D. Step Two

If the grievance is not satisfactorily resolved at Step One, the grievant may appeal the grievance to the Superintendent by submitting the grievance to the Superintendent within seven (7) days of receipt of the Step One response. Within seven (7) days after the receipt of the grievance, the Superintendent shall hold a meeting with the grievant, an Association representative, and such other persons as may be deemed appropriate, to discuss and

attempt to resolve the grievance. The grievant shall be notified in writing of the Superintendent's decision at Step Two within seven (7) days after the meeting.

E. Step Three

Within seven (7) days of receipt of the Step Two response, or if the Superintendent fails to file a timely response at Step Two, the Association may appeal the grievance to arbitration by notifying the Superintendent of its intention to appeal to arbitration. The arbitrator shall be selected from a list supplied by the American Arbitration Association. All procedures relative to arbitration shall be according to the voluntary rules and regulations of the American Arbitration Association. The arbitrator shall not relative to arbitration have the authority to add to, subtract from, modify, change or alter any of the provisions of this contract. The decision of the arbitrator shall be binding. The cost for the arbitrator shall be shared equally by the parties.

F. Miscellaneous Provisions

1. The failure to timely file a grievance, or to appeal a grievance to the next step of the grievance procedure, shall render the grievance null and void and no longer subject the grievance procedure. The failure of the Board to timely respond at any step shall automatically advance the grievance to the next step.
2. All meetings provided for in this procedure shall be held at a mutually agreed-to time which will afford a fair and reasonable opportunity for all persons, including witnesses necessary to be present to attend. Whenever possible, grievance meetings shall be held during non-working hours. When a grievance meeting is held during working hours, only the grievant will be paid for the time spent at the grievance meeting or hearing.
3. No grievance meeting or adjustment of a grievance shall take place without the knowledge of the Association. The Association shall be entitled to attend and participate in any grievance meeting or hearing. The president of the Association shall receive a copy of the written decision rendered at each step of the grievance procedure.
4. The time limits for filing and processing a grievance may be extended upon mutual consent of the parties.
5. The Association shall have the exclusive right to determine whether to proceed to the arbitration step of the procedure.
6. A grievance may be withdrawn by the grievant at any time without prejudice.
7. If a grievance appears to rise from the actions of an authority higher than the immediate supervisor, or which effects a group of members of the Association, or which involve more than one supervisor, or which involves the Superintendent, or which alleges a violation of Association rights, may be submitted at Step Two described herein and the processing of such grievance shall commence at Step Two. In addition, the parties may mutually agree to expedite grievance arbitration and advance the grievance directly to arbitration.

ARTICLE 5 - EMPLOYMENT PRACTICES

A. Seniority

1. Seniority Defined: Seniority shall mean the length of continuous employment in a bargaining unit position as follows:

- a. Seniority shall begin to accrue from the first day worked in a bargaining unit position.
 - b. Seniority shall accrue for all time an employee is on active pay status or is receiving workers' compensation benefits for the same amount of time as the accrued sick leave they have at the time of the disability.
 - c. Time spent on inactive pay status (unpaid leave or layoff) or in a non-bargaining unit position, shall not contribute to the accrual of seniority but shall not constitute a break in seniority.
 - d. For layoff and recall (RIF) purposes only, employees employed under a continuing contract shall have greater seniority than employees employed under limited contracts.
2. Equal Seniority: A tie in seniority shall occur when two (2) or more employees have the same amount of seniority credit as determined by the application of the seniority provisions above. Ties in seniority shall be broken by the following method to determine the most senior employee:
- a. Full-time employees shall be more senior than part-time employees, and then;
 - b. The employee who has the greatest number of accumulated days of prior, substitute or part-time service in the District not previously counted as continuous employment, and then
 - c. The employee with the earliest date of hire as determined by the date of the Board meeting at which the staff member was hired, and then the order of hire at the Board meeting where the employee was initially hired and then, if a tie still remains,
 - d. By lottery, with the most senior employee being the one whose name is drawn first, etc. This procedure shall be implemented in the presence of a designated Association representative.
3. Loss of Seniority: Seniority shall be lost when an employee retires or resigns, discharged for cause, or otherwise leaves the employment of the employer.
4. Posting of Seniority List: In addition to the posting provisions required under the reduction in force provisions, the Board shall prepare and post a seniority list, ranking each employee in the employee's area(s) of certification. The employee's most recent date of hire and contract status (limited or continuing and duration of contract) will be listed after the employee's name. The list shall be posted by January 30 of each year, and a copy provided to the Association president.

B. Vacancies, Transfers, and Promotions

A vacancy is an opening resulting from the creation of a new position, or an opening resulting from the reassignment, resignation, retirement or termination of an employee, which the Board decides to fill.

The Board will mail a notice of all vacancies to each staff member at least eight (8) working days, or five (5) days if the vacancy arises within the two (2) weeks prior to the onset of school, before any selection is made to fill the vacancy.

Such vacancy postings shall include the date of posting, the application deadline, the qualifications for the position, the location of the position, the hours of work, the months of employment, and the salary for the position.

Interested bargaining unit members shall apply in writing to the Superintendent or designee within the applicable posting period.

Vacancies shall be filled by the most qualified applicant as determined in the sole discretion of the superintendent. In the event all relevant factors are equal, the applicant from within the bargaining unit with the greatest seniority will be offered the position.

With the public announcement of the selection, the Employer shall make known its decision as to which applicant has been selected to fill the posted position. Each applicant shall be so notified in writing with a copy provided to the Association. The Superintendent may make temporary assignment of personnel into positions in which a vacancy exists. Such appointment shall extend until selection procedures are completed, but not beyond the current school year and not to exceed (60) days, whichever is shorter, unless a replacement willing to accept such vacancy cannot be found.

Voluntary Transfers: Voluntary transfer shall be defined as any transfer where affected staff have made application for such transfer or where such affected staff have agreed to such transfer.

Involuntary Transfers: Involuntary transfers shall be defined as any transfer that is not voluntary.

The parties agree that involuntary transfer of bargaining unit members are to be effected only when there are no qualified voluntary applicants, shall not be initiated for disciplinary reasons and shall be in inverse order of seniority except in such cases where in the sole discretion of the Superintendent a non-seniority transfer can be justified.

The Superintendent retains under this Agreement the sole authority and discretion to assign and reassign employees, except as such authority may be specifically limited by this Agreement.

C. Assignment Notice

Prior to the end of each school year, employees covered by this Agreement shall be provided written notice containing the employee's tentative assignment area and/or teaching assignment for the following school year, which notice shall also indicate the tentative location of the assignment if a tentative location has been determined.

D. Evaluation Procedure

OTES Teachers Only: All bargaining unit members meeting the statutory definition of "teacher" pursuant to Ohio Revised Code shall be evaluated in accordance with the Board adopted evaluation policy and any memoranda of understanding entered into by the parties.

Non-OTES Teachers: Bargaining unit members who do not meet the statutory definition of teacher shall be evaluated according to past practice, except as otherwise required by law.

1. Retention and Promotion Decisions: The Board shall utilize the Reduction in Force procedure set forth in Article 5(F) process for retaining or not retaining a teacher.

2. Removal of Poorly-Performing Teachers: Teachers who are determined by the Superintendent to be poorly-performing teachers, and those who are not found to be poorly performing, but that the Board has decided should be non-renewed, shall be non-renewed in accordance with ORC Section 3319.11.

3. Professional Development: The Board's plan for the allocation of financial resources to support professional development is as follows:

The Governing Board of Education will allocate financial resources to support professional development through the use of Governing Board funds. This allocation will be at the sole discretion of the Governing Board of Education.

4. Response to Evaluation: The teacher shall have the right to make a written response to the evaluation, and to have it attached to the evaluation report to be placed in the teacher's personnel file. A copy, signed by both parties shall be provided to the teacher.

E. Contract Sequence

The initial employment contract of an employee covered by this Agreement shall be for a term not to exceed one year. Thereafter, if an employee is re-employed at the expiration of an expiring limited contract, the successor contract shall be for a term of not less than the term provided for in the following schedule, unless the Board of Education has provided the teacher written reasons directed at the employee's professional improvement, by June 1 of the year which the contract expires, for offering the teacher employment for a shorter term:

First Renewal	One year contract;
Second Renewal	Two year contract;
Third Renewal	Three year contract;
Fourth Renewal	Five year contract.

An employee for whom the Superintendent intends to recommend for a contract for a shorter term than the employee would otherwise be eligible for under the provisions of this Article shall be notified in writing on or before May 2 of the intended recommendation, and said notice shall include the reasons for the recommendation. Any staff member so notified shall be entitled, upon request, to a conference with the Superintendent and afforded the opportunity to respond to the reasons listed in said notification. The conference shall be held within ten (10) school days of the request for the conference.

F. Reduction in Force

In the event the Board of Education determines that it is necessary to reduce the number of bargaining unit staff positions, it may do so only for one of the following reasons:

1. Lack of or declining enrollment in a unit or program operated by the Board;
2. A unit or program operated by the Board as transferred to or taken over by a local school district;
3. Return to duty of regular staff after leave of absence or temporary assignment;
4. As a result of the suspension of schools or territorial changes affecting the District;
5. Overstaffing in an area of certification for reasons other than declining enrollment;
6. For financial reasons.

In the event of a reduction in staff, the following procedure shall be followed. To the extent possible, the number of staff members affected by a reduction in force shall be minimized by not employing replacements for staff members who retire, resign or whose limited contracts are not renewed for reasons other than reduction in force.

G. Suspension-Renewal Suspension

Reduction needed beyond the number resulting from attrition shall be accomplished by suspension of existing limited contracts and/or renewal suspension of expiring limited contracts and/or necessary suspension of continuing contracts. Those contracts to be suspended and/or renewal suspended, i.e., those staff to be laid off, will be determined as follows:

1. The Board will determine the positions to be reduced.
 - a. Employees in a position to be reduced will be laid off in reverse order of seniority. Part-time employees in the position shall be laid off, by seniority, before full-time employees.
 - b. An employee in the position to be reduced may elect to displace any less senior staff member in any other area of certification for which the more senior staff member is also certificated. An employee electing to displace another employee shall notify the Superintendent within ten (10) days of receipt by the Association president of layoff provided for in paragraph 3 below.
2. The Association president and all employees affected shall be notified of a layoff no later than thirty (30) calendar days prior to the work day that the layoff is to begin. Said notice shall include the reasons for the layoff, the positions to be reduced, and the intended effective date of the layoff.
3. Staff subject to or affected by such suspensions will be offered open positions(s) for which they have temporary certification or are otherwise legally qualified to fill said position.
4. Employees whose contracts are suspended as a result of a reduction in force will be placed on recall list for up to twenty-four (24) months from the date of the reduction. Members on the recall list shall have the following rights:
 - a. Staff members on the recall list will be recalled in order of seniority for vacancies in positions for which they are certified/licensed, or have obtained a supplemental license and informed the Board of such supplemental licensure.
 - b. If a vacancy occurs, the Board will send an announcement to the last known address of all employees on the recall list who are certified for the vacant position. Employees shall be responsible to keep the Board informed of his/her current address or whereabouts. Employees shall respond in writing to the notice of vacancy within five (5) work days. The most senior of those responding will be reinstated to the vacant position. Full-time employees shall be recalled, by seniority, before part-time employees. Any employee who fails to respond to a notice of vacancy shall be removed from the recall list.

- c. No new teacher will be employed to fill a vacancy before all employees on the recall list who are certified/licensed for the vacancy have either declined the vacancy or failed to respond to the notice of vacancy.
- d. So long as any employee remains on layoff status, no current non-bargaining unit employee shall be assigned to fill a vacancy before all employees on the recall list who are certified/licensed for the vacancy have either declined the vacancy or failed to respond to the notice of vacancy.
- e. An employee on layoff status shall notify the Superintendent if he/she would perform substitute teaching service while on layoff. Employees on layoff status so notifying the Superintendent shall be called for substitute teaching service in order of seniority.
- f. An employee on the recall list will, upon acceptance of the notification to resume active employment status, return to active employment status with the same seniority as he/she had at the time of layoff. The recalled staff member's placement on the salary schedule and sick leave accumulation shall be determined in accordance with this Agreement and/or the Ohio Revised Code, as appropriate
- g. Laid off employees may, for the duration of their recall eligibility or for that period required by law, whichever is greater, elect to continue participation in any or all of the group insurance plans available to regular employees by paying the full premium for said insurance (s) when due to the Treasurer.

H. Personnel File

The personnel file for each bargaining unit member shall be maintained in the Administration office.

During normal working hours, and upon reasonable advanced request, a bargaining unit member shall have the right to review his/her personnel file in the Administration office, in the presence of the superintendent or his/her designee. The bargaining unit member shall have the right to have a representative present with him/her while reviewing the file.

Prior to placing a document related to a bargaining unit employee's job performance in the employee's personnel file, the employee shall be shown the document, given the opportunity to initial the document, and shall be provided a copy of the document without cost to the employee. If the bargaining unit member refused to initial the document, it may be placed in the file. The bargaining unit member's initials shall not constitute agreement with the content of the document but only that the document has been inspected.

A bargaining unit member shall have the right to attach a written reply/rebuttal to any material being placed in his/her file, and the reply shall be attached to the material in question. Anonymous letters or materials shall not be placed in a bargaining unit member's personnel file.

All personnel information shall be maintained with such accuracy, relevance, timeliness, and completeness as is necessary to assure fairness and any determination made with respect to the staff member on the basis of the information. If any material or information contained in an employee's personnel file are inaccurate, irrelevant, untimely, or incomplete, such material shall be removed from the employee's file upon request by the employee in accordance with Ohio Law.

ARTICLE 6 - LEAVES

A. Sick Leave

1. Each full-time professional staff member shall be entitled to fifteen (15) days sick leave with pay for each year under contract and shall accrue sick leave at the rate of one and one-fourth (1¼) days for each calendar month under contract. Sick leave shall be cumulative to two hundred (200) days except that all staff with the maximum accrued sick leave that use less than fifteen (15) days of sick leave per year will continue to be credited with the maximum sick leave regardless of when during the school year such sick leave had been used.
2. Each newly hired staff member who has no accumulated sick leave will be advanced an accumulation of sick leave of at least five (5) days. Each professional staff member under regular, full-time contract will continue to accumulate sick leave at the rate of one and one-fourth (1¼) days per month while on paid sick leave.
3. Those employees who render part-time, per diem, or hourly service, will be entitled to sick leave in proportion to the time actually worked.
4. Any professional staff member having terminated employment with the Board will have their accumulated sick leave reinstated upon reemployment provided such sick leave has not been used in the employ of another board of education or other agency of the State of Ohio covered by such provision.
5. A professional staff member reemployed by the Board who, since leaving the employ of the Board, has been employed by another board(s) of education or by state, county, or municipal government(s) in Ohio, will receive full credit up to 200 days for sick leave accumulated while in the prior employ of the Board and/or while in the employ of other agencies of the State of Ohio.
6. Any professional staff member being employment by the Board who, since leaving the employ of the Board, has been employed by another board(s) of education or by state, county, or municipal government(s) in Ohio will receive full credit up to 200 days for the sick leave accumulated in this previous employment.
7. Professional staff members absent for purposes of sick leave when school is canceled and when staff are relieved of their regular teaching duties for that day, will not be charged with sick leave.
8. Professional staff members should notify their immediate superior or designee of any absences as soon as possible so that appropriate arrangement can be made to secure a substitute. Except in emergency situations, lesson plans from the teaching staff must be available to the substitute.
9. Sick leave shall be granted for absence due to personal illness, pregnancy, injury, exposure to contagious disease which could be communicated to others, and for absence due to illness, injury or death in the employee's immediate family.
 - a. Injury and/or Illness in the Immediate Family: For purposes of injury or illness in one's immediate family, immediate family will be interpreted as spouse, child, mother, father, sister, brother, step-child, step-parent, or any other relative as approved by the Superintendent on a case-by-case basis. The maximum amount of sick leave for purposes of an injury and/or illness of an adult child over the age of 26 shall be 3 days. Additional days may be approved by the Superintendent.

- b. Death in Family: In the event of death in the employee's family, immediate family shall be defined as parent, child, spouse, sister, brother, grandparent, grandchild, step-child, step-parent, and in-laws or any other relative approved by the Superintendent on a case-by-case basis.
10. Each professional staff member will use the KIOSK on-line system to justify the use of sick leave, and it must be approved by the Superintendent. If medical attention is required, the employee shall list, on the same form, the name and address of the attending physician and the date when the doctor was consulted. An employee using sick leave for more than four (4) consecutive days may be required to provide a written medical statement or other appropriate documentation justifying the use of sick leave.

B. Personal Leave

Employees covered by this Agreement shall be entitled to up to three (3) days of personal leave, with pay, per school year. Such leave shall not accumulate from year to year. Personal leave is to be used for the purpose of transacting business or attending to affairs or problems of a personal nature which cannot be scheduled or attended to outside the employee's regular work hours. This means that personal leave shall not be used to extend a holiday, a vacation period, or any other leave period, or for any other recreational purpose, or in lieu of sick leave, except where sick leave has been exhausted, or for seeking employment or engaging in other employment, or for any other reason not consistent with the purpose as described above for which personal leave is to be used.

Except in cases of emergency or in situations beyond the control of the employee, personal leave shall not be used within twenty (20) school days of the beginning or end of the school year.

Except in cases of emergency or beyond the control of the employee, a request to take personal leave must be made through the KIOSK on-line system and submitted to the superintendent at least five (5) days prior to the date for which the leave is requested. Except in cases of emergency or situations beyond the control of the employee, personal leave must be approved in advance, through the KIOSK system, by the Superintendent or his designee in order for it to qualify as such under this Article. Personal leave may be taken in one-fourth day increments.

C. Assault Leave

Pursuant to Section 3319.143 of the Ohio Revised Code, a member of the bargaining unit who is physically disabled as a result of a physical assault on him/her while the member is performing duties required by his/her employment contract with the Board and occurring on school premises or during a school-sponsored function and not caused by another employee of the District shall be entitled to assault leave.

When such assault results in absence from duty for medical reasons, such absence shall be at no loss in pay and shall not be chargeable for sick leave to a maximum of twenty (20) school days per member each school year. This may be extended by the Board of Education. Medical verification shall be furnished to the Superintendent or designee for all assault leave requests of more than one (1) day.

D. Professional Leave

The Superintendent may grant a day or days of leave without loss of pay to employees covered by this Agreement to attend meetings, seminars, classes, workshops that will further

the professional development of the employee. Application for professional leave should be made on the KIOSK on-line system at least ten (10) days in advance of the meeting. If the leave request is denied, the Superintendent will provide, in writing, the reason for the denial. The employee will be reimbursed for expenses verified by receipts to the amount approved in advance by the Superintendent.

E. Child Care Leave

Upon the request of any bargaining unit employee, a leave of absence without pay shall be granted to care for a newborn infant or for the adoption of a minor child. Such leave shall be for the remainder of the semester in which such leave is requested and, at the option of the employee for the subsequent two (2) semesters. Employees returning from child care leave shall do so at the start of a semester. An employee on child care leave may return to his/her duties sooner than initially requested, including in the middle of a semester, with the approval of the Board, which approval shall not be unreasonably withheld.

F. Jury Duty

An employee called for jury service or who is subpoenaed to appear in any judicial proceeding to which the employee is not a party shall be released without loss of pay provide the employee submits the remuneration, except transportation costs, received to the Treasurer's office.

G. Other Unpaid Leaves of Absence

Pursuant to ORC 3319.13, upon the written request of an employee covered by this Agreement, and with the approval of the Board of Education, an employee may be granted a leave of absence for a period of not more than two (2) consecutive school years for educational or professional or other purposes, and shall be granted such leave where illness or other disability is the reason for the request.

H. Provisions Applicable to All Unpaid Leaves of Absence

The Board of Education shall continue to carry on the School District's payroll records, employees on unpaid leaves of absence for the purpose of the group term life, hospitalization, surgical or major medical insurance. The Board shall not be obligated to pay the premium for these insurances for those employees on leave except as provided for under the Family and Medical Leave Act (FMLA), but the employee may, at his/her option, continue said insurances by paying the full premium due in advance to the Treasurer. No other compensation or fringe benefits shall be provided.

Upon returning to service at the expiration of an unpaid leave of absence, the employee shall resume the contract status which he/she held prior to the leave.

The term of an employee's contract shall not be extended by an unpaid leave of absence, and in the event that an employee's limited contract expires while on such leave, the employee's contract may be renewed or not renewed in accordance with the provisions of this Agreement and ORC 3319.11.

ARTICLE 7 - PROFESSIONAL COMPENSATION

A. Salary Placement and Payroll Practices

Each bargaining unit member covered by this Agreement will be paid the salary at the rate set forth in the basic salary schedule for the applicable school year consistent with their

training and experience and supplemental salary schedule where applicable. The salary schedules applicable during the term of this Agreement are attached hereto.

For purposes of salary schedule placement, one year's experience shall be defined as not less than 120 days of teaching experience in the same school district during a given school year. A year of military service shall be defined as twelve (12) months or major fraction (2/3 or greater) thereof.

Staff members with outside teaching experience employed by the Board shall be given credit for up to twelve (12) years of service outside the District, whether private or public, or for up to five (5) years of military service in the Armed Forces of the United States or any combination of both not to exceed twelve (12) years of service for proper placement on the salary schedule. Bargaining unit members on extended service contracts shall be paid their per diem rate for each day of such service.

B. Advancement on Salary – Additional Training

A staff member may advance to a higher level on the salary schedule by fulfilling the following:

1. The affected staff member shall provide evidence of completed additional graduate hours from an accredited college or university.
2. Said hours must be verified by transcript or letter from the college or university dean where the course work was completed. The salary adjustment will be made no later than September 15 and retroactive to the beginning of the current school year following receipt of the transcript and/or letter of verification to the Superintendent.

C. Pay Periods

Employees covered by this Agreement shall be paid in twenty-six (26) equal installments over a twelve (12) month period.

All salaries shall be paid through direct deposit. Employees will continue to receive their regular pay stub, containing payroll information, including but not necessarily limited to withholding of taxes and annuities and leave accumulation and usage.

D. Deductions

Deductions from pay may be made for the following items:

1. Annuities (from one of the four TSA companies in use)
The enrollment period for TSA's will be opened twice each school year.
2. Insurance
3. Political Contributions
4. Credit Union / Bank Savings Account
5. Other deductions as may be required by law or may be agreed to by the Treasurer of the Board
6. 125 Plan

A payroll deduction authorization form must be signed by the individual requesting the deduction and submitted to the Treasurer of the District. Such authorizations must be submitted no later than October 1 of each year. Except where minimums are otherwise required by the company or other government agencies, a minimum withholding shall be at least \$1.00.

Except for Association dues, withholding as otherwise provided herein, said deduction(s) shall commence with the next regular paycheck within fifteen (15) days or the second regular paycheck, whichever comes first, following submission of the request and shall continue in equal amounts from each successive check for the remainder of the school year. Authorized withholding may be increased or decreased or halted, but such adjustment may be made only once during each half of the year.

E. Base Salary

Base salary shall be defined as the regular salary paid to a full-time staff member with a bachelor's degree and no experience.

F. Daily or Per Diem Rate Defined

1. The daily or per diem rate shall be calculated by dividing the salary, as listed on the salary schedule in this Agreement, corresponding to the affected staff members training and experience by the number of work days in the adopted school calendar for regular full-time staff (excluding extended service).
2. Salaries of persons working full days but less than a complete school year shall be calculated on the number of actual days worked times the daily rate.

G. Salary of Part-time Staff

1. Full day, partial week:

Staff employed on a schedule of full days for less than a full school week will be paid on a per diem basis for each day they are scheduled to work.

2. Partial day schedule:

Staff employed on a partial day schedule will be paid using one of the following methods of computation:

- a. Part-time high school, junior high staff who do not receive a full planning period shall be paid on the basis of the number of teaching/work assignment periods, excluding planning period(s), for which they are contracted as a fraction of the total teaching/work assignment periods, excluding planning period(s), of a regular full-time staff member assigned to the same or similar position(s).
- b. Part-time high school and junior high staff who receive a full planning period shall be paid on the basis of the total number of teaching/work assignment periods and the planning period as a fraction of the total teaching/work assignment periods including the planning period of a regular full-time staff member assigned to the same or similar position.
- c. Where the staff member is employed and assigned to a part-time position where the school day is not subdivided into periods, the salary will be computed on the basis of the staff member assigned pupil contact time as a

fraction of the total pupil contract time required of a full-time staff member assigned to the same or similar position.

Part-time staff shall be entitled to Board-paid fringe benefits prorated to the service for which they are contracted (prorated on the basis of their salary to that of full-time staff with the same placement on the salary schedule). (Amended 8/25/95).

H. Waiver of Salary Notification

The parties hereby agree that the Board shall not be required to provide a salary notice pursuant to OR 3319.12 for the duration of this Agreement.

I. STRS Pick-Up

The Board agrees to annuitize each bargaining unit member's total contribution to STRS by deducting that amount from the member's pay before each member is paid.

The procedure shall be as follows: The Board shall designate each member's mandatory contribution to the State Teachers Retirement System of Ohio as "picked up" by the Board although such contribution shall continue to be designated as employee contributions. The amount of the member's income reported by the Board as subject to federal and state income tax shall be the member's total gross income reduced by the then current percentage amount of the member's mandatory STRS contribution. No member's total salary shall be increased by such "pick up", nor shall the Board's total contribution to STRS be increased thereby. There shall be no increased cost to the Board resulting from this Article except incidental administrative costs necessary to implement this Article.

It is expressly understood that all employees covered by this collective bargaining agreement shall be subject to this provision as a condition of their employment.

The members of the bargaining unit acknowledge that the Board is in no way liable to them as a result of the implementation of this program at their request and that said members assume any and all liability as a result of an adverse ruling by the Internal Revenue Service.

J. Health Insurance Coverage

The Board shall provide insurance to employees covered by this contract through the health insurance plan provided by the Putnam County Schools Insurance Group or any successor health insurance plan that may be provided. Part-time staff shall be entitled to Board-paid fringe benefits prorated to the service for which they are contracted (see subsection G herein).

The provisions for the full scale/spectrum 125 Plan with a mutually-agreed upon company will be continued for the duration of this Agreement. The amount of the health insurance premium to be paid by an employee may be contributed as part of the 125 Plan

The Board shall pay 85% for the health insurance premium for single and family coverage for the PPO health insurance plans currently offered by the Putnam County Schools Insurance Group.

The Board shall pay 90% for the health insurance premium for single and family coverage for the High Deductible (H.S.A.) health insurance plans currently offered by the Putnam County Schools Insurance Group. For the High Deductible plans, the Board will contribute \$2,000.00 annually for family plans and \$1,000.00 annually for single plans into the

employee Health Savings Accounts. The payments will be split into 2 equal payments made in January and June.

In the event the current Putnam County Schools Insurance Group is dissolved, the Board and the Association will meet to negotiate health insurance.

K. Severance Pay

Any staff member with a minimum of ten (10) or more years of accumulated service with the state, any political subdivision, or any combination thereof who elects to retire shall be paid 25% of his/her accumulated and unused sick leave. The maximum payment which shall be made is 25% of 200 days (50 days).

The rate of pay for all such accumulated days shall be the per diem rate of the annual salary as determined by the salary schedule in effect at the time of last service.

An employee who meets the service requirements set forth above and who dies while in the employ of the Board shall be entitled to the severance pay provided for in this section. In the case of death, severance will be paid to the beneficiary designated by the employee on the Designation of Beneficiary for Receipt of Severance Benefits Form. In the absence of a beneficiary designation, severance shall be paid to the estate of the deceased employee pursuant to R.C. 2113.04.

Payment of severance pay shall extinguish all obligations of the employer for any further payment or restoration of unused sick leave.

L. Travel Reimbursement

Reimbursement for mileage for those staff that are required to drive their personal vehicles will be provided at the rate set annually by the Board, which shall not be less than the previous rate, except as necessary to remain no higher than the standard business mileage rate set by the IRS per mile to the nearest mile. Mileage will be paid for all travel related to the affected staff member's assignment beyond home to initial point of arrival within the county and final point of departure within the county to home for the day. Mileage will also be paid for all authorized trips outside the county.

M. Group Life

The Board shall purchase from a carrier licensed by the State of Ohio group term life insurance for each employee included in the bargaining unit in the amount of \$15,000, plus an equal amount of accidental death and dismemberment coverage. The Board shall pay 100% of the premium for said group life insurance.

ARTICLE 8 - WORKING CONDITIONS

A. Work Year

The length of the school year shall be 185 days for regular teaching staff and staff not on extended service contracts.

B. Work Week

The normal work week for all bargaining unit members shall be Monday through Friday.

C. Work Day

Except as noted below, the normal length of the school day for full-time staff assigned to the county building shall be eight (8) hours, with one (1) hour for lunch.

The length of the day for staff assigned to one or more of the local school sites shall be the length of day in that school building.

D. Early Dismissal-Teacher In-Service

Release time will be allotted in the case of in-service meetings held during the day which staff members are required to attend.

E. Parent-Teacher Conferences

The schedule for parent/teacher conferences for staff assigned to local buildings will be the same as that of the local school.

F. Other Work Hours/Meetings

Except as noted above, bargaining unit members shall not be required to attend or otherwise participate in curriculum development, text book selection, college course work, in-service programs and/or workshop except where time for such activities is provided during the context of the regular work day or supplemental compensation is provided.

G. Calamity Days

Nothing in this Agreement shall require the Board to keep offices and buildings open in the event of inclement weather or when otherwise prevented by an act of God, or an event that causes the closing of schools or an interruption of services for students. When all the schools are closed to students and this results in an interruption of services for students, due to the above conditions, bargaining unit members shall not be required to report to their job assignments and shall suffer no loss of salary. . Staff may be required to perform their regular duties through virtual or other remote services during regular work years, weeks, and days to comply with government ordered school building closures or determinations made by the leadership of the local school sites.

H. Preparation/Conference Time/Coordination Time

Staff members who are required to receive planning/coordination time under state minimum standards, shall be provided such time during the normal work day.

I. Supplies

Each department will be given a budget. The supervisors shall meet with his/her staff to discuss the amount of budget allocated to each department and the procedures for ordering at least one (1) month prior to deadline for submission of purchase orders.

Staff shall be permitted to prioritize their purchase requests for purchased supplies, materials or teaching aides and be assured of receipt of same providing such orders are within the budgetary limits established for the affected staff member.

A copy of all staff submitted purchase orders shall be returned to the staff with a clear indication as to the approval or disapproval in whole or part of the items (materials/equipment ordered). No substitution of such staff orders will be made without the express knowledge and consent of the affected staff member.

Each spring prior to April 1, staff will prepare a list of miscellaneous and incidental supplies for use in individual classrooms or work assignment areas. Each supervisor will consolidate such lists for the purposes of ordering such supplies.

Upon approval of the Superintendent, staff members will be authorized to supply funds toward the discretionary/incidental purchase of materials, supplies, books, equipment or any other such teaching/learning materials to be used in conjunction with that staff member's current assignment.

J. Aides/Education Assignments

Aides not required to be assigned exclusively by an IEP may be assigned to more than one classroom. Classroom teachers who are not provided or assigned full-time aides will be provided communication devices so as to enable the affected staff member to summon help when needed.

K. Administration of Medical Procedures/Medications

Staff shall not be required to administer any medication or perform any medical procedure such as but not necessarily limited to catheterization, physical therapy, and occupational therapy unless the affected staff member is licensed and/or trained to do so.

L. Custodial Care Facilities

Teachers and/or aides responsible for custodial care of students shall be provided with sanitary/sterile materials as are necessary to provide the service to the affected student such as but not necessarily limited to the following: changing mats, disposable gloves and sterilizing solution.

M. Local Professional Development Committee

Prior to September 1 of each school year, the Association and Board shall establish a Local Professional Development Committee (LPDC) pursuant to applicable state law (SB 230). The Committee shall be comprised of three (3) bargaining unit members selected by the Association and two (2) administrative personnel selected by the Board. When reviewing or approving an administrative license, one (1) bargaining unit member shall be removed from the Committee and an additional appointee of the Board shall be placed on the Committee.

A Chairperson shall be elected by majority vote of the LPDC. A Secretary shall be elected by a majority vote of the LPDC and shall be responsible for Committee minutes and will assure the secure storage of the confidential materials used by the LPDC.

Decisions shall be made by a majority vote of the LPDC members present and voting. Three (3) members present shall constitute a quorum of which two (2) shall be bargaining unit members.

Appeals of LPDC decisions shall be made to the LPDC within thirty (30) calendar days of the LPDC decision. A second appeal may be made to the County Superintendent within thirty (30) days of the LPDC appeal hearing.

Each Committee member except the Secretary shall be paid \$20.00 per hour up to a maximum of 25 hours for work performed outside the regular work day. The Secretary shall be paid \$20.00 per hour up to a maximum of 50 hours for work performed outside the regular work day.

Training for the LPDC members shall be in addition to other professional leave.

N. Entry Year Program

Entry year program mentors and mentees will be compensated for participating in the program in accordance with current program guidelines.

O. IEP Relief Stay

The relief time determined to be necessary at the sole discretion of the superintendent or superintendent's designee will be provided for the development of individualized education plans.

P. Hepatitis B Vaccination

The Board shall make available the Hepatitis B vaccine and vaccine series to all employees who have occupational exposure, and post-exposure evaluation and follow up to all employees who have been exposed.

If the employee declines the vaccine, the employee will fill out a declination form provided by the Board. If the employee changes his/her mind, the Hepatitis B vaccine will be made available.

ARTICLE 9 - DURATION

A. Separability

In the event there is a conflict between a provision of this Agreement and any applicable state law, or valid rule or regulation adopted by a state agency pursuant thereto, the terms and conditions of this Agreement shall prevail as to that provision, except as may be provided by ORC 4117.10(A).

If any provision of this Agreement is found to be contrary to law as determined by any court of competent jurisdiction from whose judgment or decree, no appeal has been taken within the time provided for doing so, such provision shall be null and void. However, the remainder of the Agreement shall remain in full force and effect.

If, during the term of this Agreement, there is a change in any applicable state or federal law, or valid rule or regulation adopted by a federal agency or a state agency pursuant thereto which affects the terms of this Agreement or which requires the Board of Education to develop policies that affect the term(s), condition(s) of employment or working condition(s), then the parties will meet to negotiate the additional term, condition of employment or working condition within ten (10) school days upon request of either party. If such negotiations do not resolve the matter within twenty-one (21) school days thereafter, the impasse procedures contained herein may be initiated by either party. Upon agreement and ratification by the parties, any substitute provisions shall be incorporated into this Agreement by written, signed amendments by the parties hereto.

B. Management Rights

The Association recognizes that the Board is the duly elected body charged by law with the authority and responsibility to establish the rules and regulations by which the Putnam County Educational Service Center will be governed, as provided in R.C. 3313.47 and R.C. 4117.08, except as may be limited by the terms of this Agreement and/or Chapter 4117 of the Ohio Revised Code. Accordingly, subject only to the limitations specifically set forth in this Agreement and/or Chapter 4117, the Association recognizes that the Board retains and reserves unto itself all powers, rights, authority, duty and responsibilities with respect to the

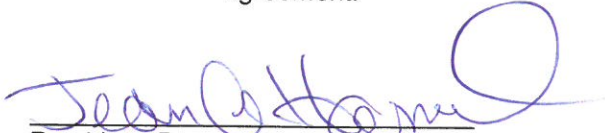
management, supervision and control of other Putnam County School Districts. The exercise of these powers, rights, authority, duties and responsibilities by the Board, the adoption of policies, rules, regulations, and practices in furtherance thereof, and the use of judgment and discretion in connection therewith, shall be limited only by the specific and expressed terms of this Agreement and/or Chapter 4117 of the Ohio Revised Code.

C. Amendments

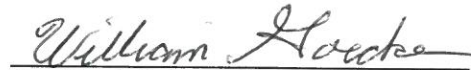
This Agreement may be altered, deleted from, added to, or otherwise modified only through voluntary mutual consent of both parties in a written, signed amendment to this Agreement. All requests for amendment and subsequent negotiations following mutual agreement to amend this Agreement shall be conducted in accordance with the terms of this Agreement except that requests for amendment may be made at any time by either party. All such amendments shall be considered finalized upon ratification by the Board and the Association.

D. Duration of Agreement.


This Agreement shall be effective on the date it is executed by the parties, and shall remain in effect until June 30, 2024. This Agreement shall be the base from which future negotiations shall proceed. If any item in this Agreement is not changed through future negotiations, it shall be carried forward, automatically, in writing into each successor agreement.




President, Putnam County
Education Association



President, Putnam County Educational
Service Center Governing Board



Negotiations Chairperson,
Putnam County Education Association



Superintendent, Putnam County
Educational Service Center

Putnam County Education Association
Salary Schedule for 2021-22 (3.0% inc)

Yrs Exp.	BA/BS 0.0380	150 Hours 0.0430	MA 0.0480
0	\$38,056 1.0000	\$39,502 1.038	\$41,671 1.0950
1	\$39,502 1.0380	\$41,139 1.0810	\$43,498 1.1430
2	\$40,948 1.0760	\$42,775 1.1240	\$45,325 1.1910
3	\$42,394 1.1140	\$44,411 1.1670	\$47,151 1.2390
4	\$43,841 1.1520	\$46,048 1.2100	\$48,978 1.2870
5	\$45,287 1.1900	\$47,684 1.2530	\$50,805 1.3350
6	\$46,733 1.2280	\$49,321 1.2960	\$52,631 1.3830
7	\$48,179 1.2660	\$50,957 1.3390	\$54,458 1.4310
8	\$49,625 1.3040	\$52,593 1.3820	\$56,285 1.4790
9	\$51,071 1.3420	\$54,230 1.4250	\$58,112 1.5270
10	\$52,517 1.3800	\$55,866 1.4680	\$59,938 1.5750
11	\$53,963 1.4180	\$57,503 1.5110	\$61,765 1.6230
12	\$55,410 1.4560	\$59,139 1.5540	\$63,592 1.6710
15	\$56,856 1.4940	\$60,775 1.5970	\$65,418 1.7190
16	\$58,302 1.5320	\$62,412 1.6400	\$67,245 1.7670
17	\$59,748 1.5700	\$64,048 1.6830	\$69,072 1.8150
20	\$61,194 1.6080	\$65,685 1.7260	\$70,898 1.8630
25	\$62,640 1.6460	\$67,321 1.7690	\$72,725 1.9110

**Putnam County Education Association
Salary Schedule for 2022-23 (2.75% inc)**

Yrs Exp.	BA/BS 0.0380	150 Hours 0.0430	MA 0.0480
0	\$39,103	\$40,589	\$42,818
	1.0000	1.038	1.0950
1	\$40,589	\$42,270	\$44,695
	1.0380	1.0810	1.1430
2	\$42,075	\$43,952	\$46,572
	1.0760	1.1240	1.1910
3	\$43,561	\$45,633	\$48,449
	1.1140	1.1670	1.2390
4	\$45,047	\$47,315	\$50,326
	1.1520	1.2100	1.2870
5	\$46,533	\$48,996	\$52,203
	1.1900	1.2530	1.3350
6	\$48,018	\$50,677	\$54,079
	1.2280	1.2960	1.3830
7	\$49,504	\$52,359	\$55,956
	1.2660	1.3390	1.4310
8	\$50,990	\$54,040	\$57,833
	1.3040	1.3820	1.4790
9	\$52,476	\$55,722	\$59,710
	1.3420	1.4250	1.5270
10	\$53,962	\$57,403	\$61,587
	1.3800	1.4680	1.5750
11	\$55,448	\$59,085	\$63,464
	1.4180	1.5110	1.6230
12	\$56,934	\$60,766	\$65,341
	1.4560	1.5540	1.6710
15	\$58,420	\$62,447	\$67,218
	1.4940	1.5970	1.7190
16	\$59,906	\$64,129	\$69,095
	1.5320	1.6400	1.7670
17	\$61,392	\$65,810	\$70,972
	1.5700	1.6830	1.8150
20	\$62,878	\$67,492	\$72,849
	1.6080	1.7260	1.8630
25	\$64,364	\$69,173	\$74,726
	1.6460	1.7690	1.9110

**Putnam County Education Association
Salary Schedule for 2023-24 (2.75% inc)**

Yrs Exp.	BA/BS 0.0380	150 Hours 0.0430	MA 0.0480
0	\$40,178 1.0000	\$41,705 1.038	\$43,995 1.0950
1	\$41,705 1.0380	\$43,432 1.0810	\$45,923 1.1430
2	\$43,232 1.0760	\$45,160 1.1240	\$47,852 1.1910
3	\$44,758 1.1140	\$46,888 1.1670	\$49,781 1.2390
4	\$46,285 1.1520	\$48,615 1.2100	\$51,709 1.2870
5	\$47,812 1.1900	\$50,343 1.2530	\$53,638 1.3350
6	\$49,339 1.2280	\$52,071 1.2960	\$55,566 1.3830
7	\$50,865 1.2660	\$53,798 1.3390	\$57,495 1.4310
8	\$52,392 1.3040	\$55,526 1.3820	\$59,423 1.4790
9	\$53,919 1.3420	\$57,254 1.4250	\$61,352 1.5270
10	\$55,446 1.3800	\$58,981 1.4680	\$63,280 1.5750
11	\$56,972 1.4180	\$60,709 1.5110	\$65,209 1.6230
12	\$58,499 1.4560	\$62,437 1.5540	\$67,137 1.6710
15	\$60,026 1.4940	\$64,164 1.5970	\$69,066 1.7190
16	\$61,553 1.5320	\$65,892 1.6400	\$70,995 1.7670
17	\$63,079 1.5700	\$67,620 1.6830	\$72,923 1.8150
20	\$64,606 1.6080	\$69,347 1.7260	\$74,852 1.8630
25	\$66,133 1.6460	\$71,075 1.7690	\$76,780 1.9110

SEVERANCE BENEFICIARY FORM

I, _____, designate the following beneficiary (ies) for receipt of payment of any severance benefits under this agreement in the event of my death. I understand that, in the absence of a designation, the severance payment would be made to the fiduciary of my estate. I hereby designate as the primary beneficiary (ies) the following person (s):

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>ADDRESS</u>	<u>PHONE #</u>	<u>PERCENTAGE</u>
_____	_____	_____ _____	_____	_____
_____	_____	_____ _____	_____	_____
_____	_____	_____ _____	_____	_____

(Total percentage for all beneficiary (ies) should equal 100%)

In the event one of the foregoing precedes me, I hereby designate as secondary beneficiary (ies) the following person(s):

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>ADDRESS</u>	<u>PHONE #</u>	<u>PERCENTAGE</u>
_____	_____	_____ _____	_____	_____
_____	_____	_____ _____	_____	_____
_____	_____	_____ _____	_____	_____

(Total percentage for all beneficiary (ies) should equal 100%)

I understand that it is incumbent upon me to keep the Board Treasurer informed of current addresses and telephone numbers of all beneficiary (ies) named by me so that they may be contacted without delay or difficulty in the event of my death.

(Date)

(Signature – Employee)

(Date)

(Signature – Employee's Spouse)

Appendix E

Required Annual Notices

Required Benefit Notices

Putnam County Educational Service Center

Important Notice from Putnam County Educational Service Center About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Putnam County Educational Service Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Putnam County Educational Service Center has determined that the prescription drug coverage offered by the Putnam County Schools Insurance Group is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Putnam County Educational Service Center coverage will not be affected. Please see the plan's benefit summary for an explanation of the prescription drug coverage plan provisions/options under the Putnam County Educational Service Center plan.

If you do decide to join a Medicare drug plan and drop your current Putnam County Educational Service Center coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Putnam County Educational Service Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Putnam County Educational Service Center changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2024

Name of Entity/Sender: Putnam County Educational Service
Contact--Position/Office: Center Michael Siebeneck – Treasurer
Address: 124 Putnam Parkway, Ottawa, OH 45875
Phone Number: (419) 523-5951

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Michael Siebeneck at Michael.Siebeneck@putnamcountyesc.org.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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. Please see the plan's benefit summary for an explanation of these benefits. If you would like more information on WHCRA benefits, call your plan administrator at (419) 523-5951.

NEWBORNS' ACT DESCRIPTION OF RIGHTS

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF PRIVACY PRACTICES

Putnam County Schools Insurance Group

Privacy Official: Michael Siebeneck – Treasurer; 124 Putnam Parkway, Ottawa, OH 45875; (419) 523-5951

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records:

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records:

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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 or 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 us using the information on page 1.
- 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 Ave, 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:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- 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:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive:

- We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization:

- We can use and disclose your information to run our organization and contact you when necessary.

Example: We use health information about you to develop better services for you.

- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Pay for your health services:

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan:

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

- We can share health information about you for certain situations such as:
 - o Preventing disease
 - o Helping with product recalls
 - o Reporting adverse reactions to medications
 - o Reporting suspected abuse, neglect or domestic violence
 - o Preventing or reducing a serious threat to anyone's health or safety

Do research:

- We can use or share your information for health research.

Comply with the law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director:

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

- We can use or share health information about you:
 - o For workers' compensation claims
 - o For law enforcement purposes or with a law enforcement official

- o With health oversight agencies for activities authorized by law
- o For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We 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.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	FLORIDA – Medicaid Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofc/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

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” (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're 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 balance 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, contact 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Continuation Coverage Rights Under COBRA

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 [*choose and enter appropriate information: must pay or aren't required to 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 [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: Miachel Siebeneck via email at MSiebeneck@putnamcountyes.org

How is COBRA continuation coverage 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, Medicare, 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 period¹ 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 the contact or contacts identified below. For more information about your rights under 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.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

Plan contact information

Contact--Position/Office:	Michael Siebeneck – Treasurer
Address:	124 Putnam Parkway, Ottawa, OH
Phone Number:	45875 (419) 523-5951