

EMPLOYEE BENEFIT GUIDE



CALCASIEU PARISH SCHOOL BOARD
BUILDING FOUNDATIONS FOR THE FUTURE

MAY 1, 2024 – APRIL 30, 2025



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**This guide is
an overview of
your benefit
options
beginning
May 1, 2024
through
April 30, 2025.**

**Prior to selecting
your benefit
elections, please
take the time to
thoroughly review
the options
presented in this
guide.**

**Summary Plan
Documents can
be obtained
from the Health
Insurance
Department &
are available at
cpsb.org**





Calcasieu Parish School Board

BUILDING FOUNDATIONS FOR THE FUTURE

Dr. Jason VanMetre, Superintendent



Welcome to the Calcasieu Parish School Board. Our Risk Management team works hard to provide our employees and their families with a competitive and comprehensive benefit offering. As a member of the CPSB family, we are excited to share information regarding these benefits with you. Please look over the attached benefits and see if any of them are right for you.

If you have any questions or if we can be of help in any way, please feel free to contact us. We are happy to help. The Health Insurance Department is located on the second floor of our Central Office at 3310 Broad Street.

Sincerely,
Dr. Jason VanMetre
Superintendent





We at Gregory Benefits & Consulting want to thank you for the opportunity to serve your insurance and employee benefit needs. We take pride in providing quality service to you and your families. Our team has 200+ years of combined experience and is capable of helping you with just about any service issues you might incur. This includes enrollment questions, claims assistance, and other benefit related concerns.

Please don't hesitate to start with us when you need help! Employee benefits can be complicated, and it is our job to make them easier for you. For your convenience, we have included a list of team members who are ready to assist you.

GREGORY BENEFITS & CONSULTING
(A Division of HUB International)
422 E. College St.
Lake Charles, LA, 70605
Phone: 337-429-2842

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Allison Mott
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Eligibility/Qualifying Events/Open Enrollment

ELIGIBLE EMPLOYEES

- Regular, full-time employees and benefit eligible part-time employees (28+ hours per week) are eligible to elect insurance benefits.
- Benefits will begin the first day of the month, following 30 days of employment.

ELIGIBLE DEPENDENTS

- Legal spouses.
- Any legal dependent up to age 26
- Any child under legal guardianship of employee up to age 26 except where otherwise noted.
- Stepchildren of employee up to age 26
- Dependent child(ren) ordered to be covered through a Qualified Medical Support Order.
- Any child meeting the criteria above who is over the age of 26 and legally incapacitated.
- Please call the Health Insurance Department or refer to Benefit Book for additional details.

QUALIFYING LIFE EVENTS (SPECIAL ENROLLMENT)

An application for special enrollment must be completed and signed within 30 days of the qualifying life event for coverage to be effective on the date other coverage is lost.

- Loss of other coverage includes:
 - i. COBRA continuation period was exhausted
 - ii. Loss of coverage due to legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the hours of employment.
 - iii. Termination of employer contributions to the other coverage.
- Special Enrollment of a dependent child due to loss of coverage under the Children's Health Insurance Program or Medicaid. *Requests for this specific loss must be received by BCBS of LA within the 60-day period following the loss of coverage. All other losses should be sent within 30 days of the loss.*
- When a person becomes a dependent of the covered employee through marriage, birth, adoption, or placement for adoption, they are eligible to enroll within 30 days of the event.

OPEN ENROLLMENT

Open enrollment for our medical, basic/optional and voluntary life, and dental insurance policies is during the month of April each year for a May 1st effective date.

During this time, you can change plans, add/drop coverage, add/drop dependents from coverage. You will receive a notification regarding open enrollment and due dates for changes to be processed.

SELF-INSURED PLAN

Calcasieu's health plan is a Self-Insured plan. A self-insured group health plan (also known as self-funded) is one in which the employer (CPSB) is responsible for each claim dollar paid – Medical and Pharmacy. The employee premiums and the CPSB premiums collected monthly are used to pay the claims. Blue Cross Blue Shield of LA administers our claims. They are paid a set rate to process claims, negotiate the best rates with hospitals, doctors, and pharmacies, and to make sure the CPSB plan is compliant with laws.

**Please note, Calcasieu Parish School Board is not part of Office of Group Benefits (OGB).*



Wellness Program / Voluntary Preventative Care Incentive

Voluntary Preventative Care Incentive

Full-time CPSB employees & retirees earning a total of 8 points by completing any of the services listed below will receive a 5% discount off the employee (not dependent) portion of the health insurance premium for the following plan year.

- ✓ Points must be earned during the program year.
- ✓ All documentation must be submitted by April 30, 2025.
- ✓ Members may email wellness information to wellness@cpsb.org.

Earn 8 of the possible 20 points listed below by April 30, 2025

• Perform blood work at CPSB's wellness fair on 9/21/24 (+) or with personal physician (*)	3 points
• Participate in the scavenger hunt at the CPSB wellness fair (+)	1 point
• Take flu, shingles, fully COVID Vaccinated, or pneumonia shot (#)	1 point each
• Attend any of CHRISTUS St Pat's health related informational seminars (+) <i>Dates TBA</i>	1 point each
• Annual Wellness Exam/Physical (#)	1 point
• Mammogram or Prostate Exam (#)	2 points
• Colonoscopy (#)	2 points
• Annual eye exam (#)	1 point
• Annual dental check-up	1 point
• Solutions EAP workshop (+) <i>Active Employees Only</i>	1 point

(+) Participant does NOT need to turn in documentation for these points

(*) Physician completes Biometric Screening Form

(#) Physician completes CPSB Wellness Program Verification Form or you may email your EOB to wellness@cpsb.org.

2024 – 2025 Premium Savings

Plan	Monthly	Annually
High Option	\$18.01	\$216.12
Low Option	\$9.00	\$108.00
PPACA	\$5.16	\$61.92
Medicare Blue Advantage (Through 12/31/24)	\$5.26	\$63.12

A unique feature of your health benefit plan is that you can keep it into retirement! There are rules however and a vesting schedule to be aware of in order to have benefits when you retire. Please refer to cpsb.org or call the Health Insurance Department for more information.

HIGH OPTION			
Plan Features	PPO		Non-PPO
Deductible			
-Individual	\$1,250		\$2,500
-Family	\$3,750		\$7,500
Annual Out-of-Pocket Maximum**			
-Individual	\$4,000		\$8,000
-Family	\$12,000		\$24,000
Doctor Office Visits	\$30 Co-Pay (Primary Care)	\$45 Co-Pay (Specialist)	55% After Deductible
In-Patient/Out-Patient Benefits	85% After Deductible		55% After Deductible
Prescription Drugs (w/ separate deductible)			
• Express Scripts Network	\$100 deductible, then: \$10 Value Drug (Tier 1) \$30 Preferred Brand (Tier 2) \$50 Non-Preferred Brand (Tier 3) \$100 Specialty Drug/Injectable (Tier 4)		
Prescription Drug Mail Order (90-day Supply)			
• Forms available in the Health Insurance Department and at the Blue Cross Office. • 90-day supply available only by mail order	\$100 deductible, then: \$30 Value Drug (Tier 1) \$90 Preferred Brand (Tier 2) \$150 Non-Preferred Brand (Tier 3) N/A Specialty Drug/Injectable (Tier 4)		

HIGH OPTION – Group Care PPO RATES

Coverage Level	Monthly
Employee Only	\$360.13
Employee + Spouse	\$809.82
Employee + Child(ren)	\$585.69
Family	\$1,035.42

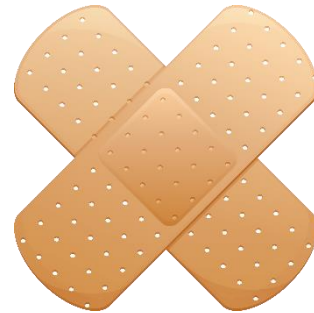


LOW OPTION

Plan Features	PPO	Non-PPO
Deductible		
-Individual	\$3,000	\$3,000
-Family	\$6,000	\$6,000
Annual Out-of-Pocket Maximum**		
-Individual	\$5,000	\$5,000
-Family	\$10,000	\$10,000
In-Patient/Out-Patient Benefits	100% After Deductible	80% After Deductible
Prescription Drugs	100% Generic 80% Name Brand After Deductible	100% Generic 80% Name Brand After Deductible

LOW OPTION – Blue Saver HSA RATES

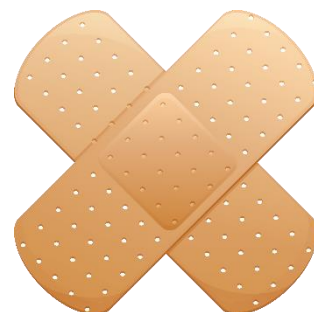
Coverage Level	Monthly
Employee Only	\$180.08
Employee + Spouse	\$404.89
Employee + Child(ren)	\$292.86
Family	\$517.70

**PPACA OPTION**

Plan Features	PPO	Non-PPO
Deductible		
-Individual	\$5,000	\$10,000
-Family**	\$9,000	\$18,000
Annual Out-of-Pocket Maximum**		
-Individual	\$5,000	\$10,000
-Family**	\$9,000	\$18,000
In-Patient/Out-Patient Benefits	100% After Deductible	80% After Deductible
Prescription Drugs	100% Generic 80% Name Brand After Deductible	100% Generic 80% Name Brand After Deductible

PPACA OPTION – Blue Saver HSA RATES

Coverage Level	Monthly
Employee Only	\$101.94*
Family	\$471.63



* Premium decrease for Employee due to Affordable Care Act Law

** Aggregate Out of Pocket – The medical and prescription deductible as well as the co-pays apply towards your out-of-pocket limit.

Medicare Advantage

MEDICARE BLUE ADVANTAGE (PPO)

Plan Features	PPO	Non-PPO
Medical Out-of-Pocket Maximum	\$1,000	\$1,000
Deductible	\$0	\$0
Inpatient Hospital	\$0 Co-Pay	\$0 Co-Pay
Inpatient Services for Mental Health/Substance Abuse	\$0 Co-Pay	\$0 Co-Pay
Skilled Nursing Facility	\$0 Co-Pay	\$0 Co-Pay
Home Health Care	\$0 Co-Pay	\$0 Co-Pay
Urgent Care	\$0 Co-Pay	\$0 Co-Pay
Emergency Room (Included worldwide)	\$50 Co-Pay	\$50 Co-Pay
Outpatient Surgery	\$0 Co-Pay	\$0 Co-Pay
Outpatient Hospital Services & Procedures	\$0 Co-Pay	\$0 Co-Pay
Partial Hospitalization	\$0 Co-Pay	\$0 Co-Pay
Blood	\$0 Co-Pay	\$0 Co-Pay
PCP Visits (Includes Routine Physical Exam)	\$0 Co-Pay	\$0 Co-Pay
Specialist Visits	\$0 Co-Pay	\$0 Co-Pay
Mental Health/Psychiatric and Substance Abuse (Outpatient)	\$0 Co-Pay	\$0 Co-Pay
Podiatry	\$0 Co-Pay	\$0 Co-Pay
Diagnostic Lab Tests	\$0 Co-Pay	\$0 Co-Pay
Radiology (diagnostic)	\$0 Co-Pay	\$0 Co-Pay
Radiology (therapeutic)	\$0 Co-Pay	\$0 Co-Pay
X-Rays	\$0 Co-Pay	\$0 Co-Pay
PT/OT/SP Therapy	\$0 Co-Pay	\$0 Co-Pay
Cardiac Rehab/CORF	\$0 Co-Pay	\$0 Co-Pay
Dialysis Treatment/ESRD	\$0 Co-Pay	\$0 Co-Pay
Part B Covered Drugs	\$0 Co-Pay	\$0 Co-Pay
Chemotherapy Drugs	\$0 Co-Pay	\$0 Co-Pay
DME & Prosthetics & Diabetes Supplies	\$0 Co-Pay	\$0 Co-Pay
Ambulance	\$0 Co-Pay per trip	\$0 Co-Pay per trip

BLUE ADVANTAGE – RATES w/ MAX BOARD CONTRIBUTION

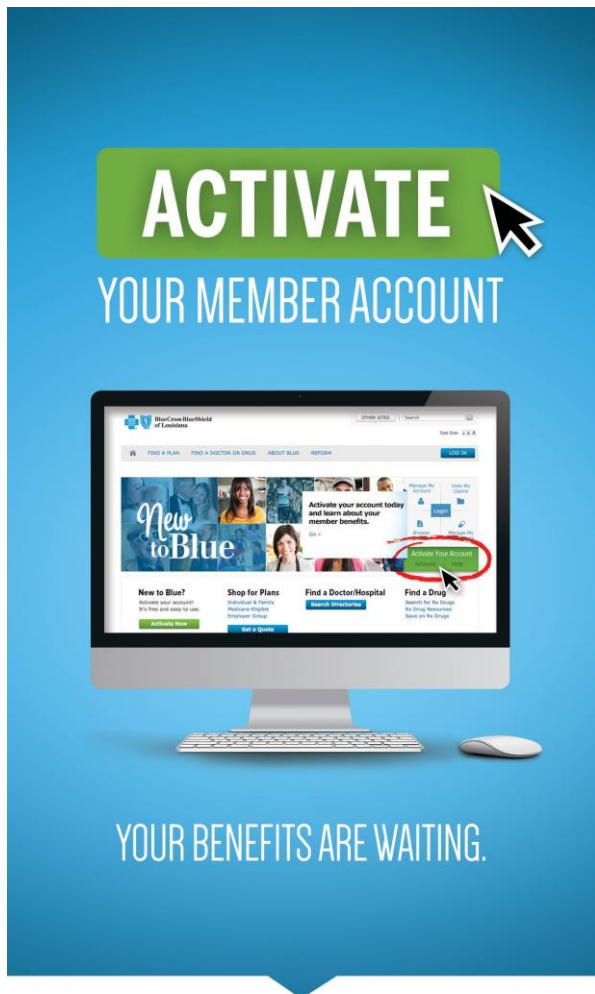
Coverage Level	Monthly
	Effective through 12/31/24
Active/Retiree w/ Medicare A & B	\$105.26
Active/Retiree + Spouse w/ Medicare A & B	\$243.76
Active/Retiree Spouse Only w/ Medicare A & B	\$138.50

BLUE ADVANTAGE PART D DRUG COVERAGE (5-tier Formulary)

Rx Deductible	\$0
Preferred Retail Co-Pay & Mail Order	30 Days: \$0 / \$12 / \$45 / \$100 / \$100 60 Days: \$0 / \$24 / \$90 / \$200 / N/A 90 Days: \$0 / \$0 / \$135 / \$300 / N/A Specialty drugs limited to 30-day supply
Non-Preferred Retail Copay	30 Days: \$10 / \$18 / \$47 / \$100 / \$100 60 Days: \$20 / \$36 / \$94 / \$200 / N/A 90 Days: \$30 / \$54 / \$141 / \$300 / N/A Specialty drugs limited to 30-day supply
Non-Preferred Mail Order	N/A
Gap Coverage	Full gap coverage for all tiers
MOOP	After your maximum out-of-pocket drug costs reach \$2,500, the plan will pay 100% of your total drug costs.

BLUE ADVANTAGE SUPPLEMENTAL BENEFITS

Flex Card Info	\$1,800 Mastercard Flex Card to pay for out-of-pocket costs, including: <ul style="list-style-type: none"> • \$1,100 for prescription hearing aids • \$300 to pay for eyewear like eyeglasses and contact lenses • \$400 for over-the-counter supplies that you can purchase at major retailers or online
Your plan also offers	<ul style="list-style-type: none"> • 100% coverage for Medicare-covered preventive and wellness care • \$0 deductible for in-network medical services • Specialist visits without a referral • Access a nationwide doctor and hospital network that covers 100 million Americans (BlueCard Program) • Dental benefits including two dental cleanings and two exams per year covered from your first dollar of expense – no deductible • Hearing benefits
Online Primary Care	Use BlueCare to see a primary care provider 24/7 with a \$0 copay through any computer, tablet or smartphone with internet and a camera.
Member Wellness Rewards	Get up to \$50 per year in gift cards from major retailers for completing approved wellness exams and/or screenings.
Fitness Program	No-cost fitness center membership (including many YMCA locations and select premium clubs or home fitness kits).
24-hour Nurse Help Line	Get help making the right choice in your health care based on your symptoms any time of the day or night.



ACTIVATE
YOUR MEMBER ACCOUNT






YOUR BENEFITS ARE WAITING.

WWW.BCBSLA.COM

HOW DO I **ACTIVATE** MY ONLINE ACCOUNT?

- 1) Go to www.bcbsla.com/activate
- 2) Enter the Member ID from your Blue Cross ID card.
- 3) Confirmation email will be sent from BCBSLA to complete registration process.

ONLINE ACCOUNT FEATURES:

- 
Download your ID card.
 Access a digital copy of your card for easy, on-the-go use.
- 
Find a doctor or hospital.
 When you need care, find someone in your network at a moment's notice.
- 
Look at your claims.
 Find out what you owe and what Blue Crosspaid for your doctor visits.
- 
Find out what your insurance covers.
 Learn what services are covered and what you pay in copays and deductibles.
- 
Price a drug.*
 Find out how much a prescription will cost you.

It's Easy!
Go paperless
 Activate your account and get your information online.



Take your online account wherever you go!
 Download the BCBSLA app on your iPhone or Android.



BlueCare

*The doctor will see you **anywhere, anytime!***

BlueCare Online Doctor Visits:

BlueCare is Blue Cross and Blue Shield of Louisiana's telehealth service. It lets you have doctor visits online, without taking time off work or school. BlueCare is 24/7 – no appointment needed – and open to you and any dependents (children, spouse, etc.) who are covered on your plan.

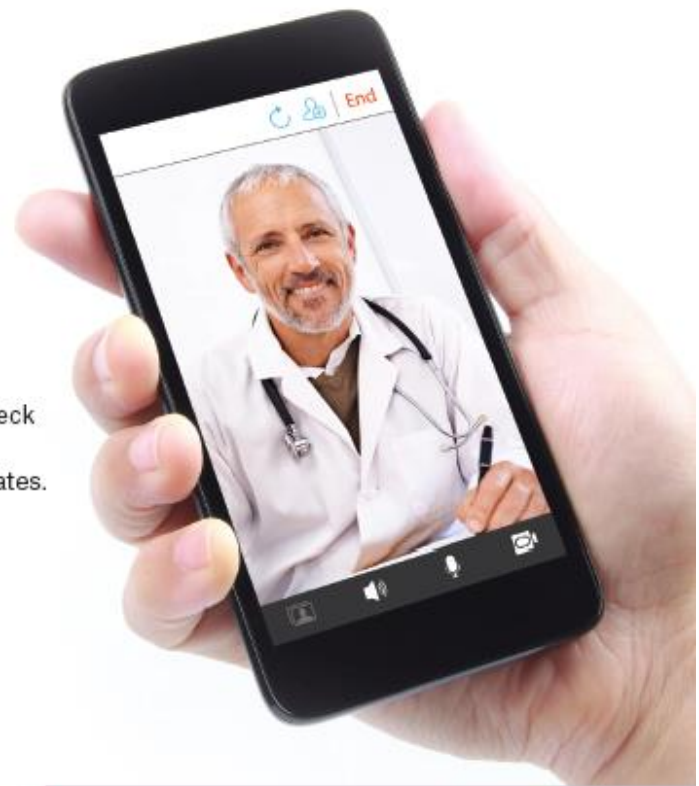
BlueCare is faster and costs less than going to an ER or urgent care clinic. It's a good way to treat minor health conditions like:

- Sinus infections
- Cough or cold
- Flu symptoms
- Rashes
- Allergies
- Bladder infections
- Pink eye
- Mild stomach bugs

You can also use BlueCare to get a prescription, to check in with a doctor if you need a follow-up visit, or when traveling. BlueCare providers are available in all 50 states.

How it works:

1. Visit www.BlueCareLA.com or **download the BlueCare (one word) mobile app** on your iPhone or Android device.
2. On your first visit, create a member account. Log into that account each time you use BlueCare online or with the app.
3. Select a physician and connect. All physicians are U.S. trained and board certified.
4. Blue Cross customers should plan to pay at the time of the BlueCare visit. Depending on your plan type and benefits, you may get a refund from Blue Cross later.



www.BlueCareLA.com



Download on the
App Store

GET IT ON
Google Play

USE YOUR DIGITAL ID CARD

when you need to
see a doctor!


Louisiana


If you do need to see a doctor in person, you now have the option to present a digital ID card. You can access your ID card from your mobile device and online through the member portal. You'll need to have an online account to access your digital ID card. If you don't have an online account, register today at www.bcbsla.com/login.

- **From the BCBSLA mobile app**, first make sure you have the latest update of the app. Once you log in, click **My ID Card** to see the ID cards available to you.
- **From the Blue Cross member portal**, log into your online account at bcbsla.com. You'll see My ID Card with a dropdown menu of the ID cards available for viewing. You can save these as PDF files.

Front

 HMO Louisiana Community Blue	
Member Name JON DOE	MEDICAL BENEFITS
Member ID XUP000111222	
Grp/Subgroup AA000ABC/1234	Deductible \$1200
RxMbr ID 000111222	Physician/Office Co-Pay \$25
RxBIN 001122 ABCDEFGHI1	Specialty Co-Pay \$50
RxGrp 0GB	
BC PLAN 000 BS PLAN 000	
04100 01320 1115R 	

Back

	www.bcbsla.com Customer Service 800-496-2583 Find a Provider 800-810-2583 Authorizations 800-523-6435 Dental Questions 866-445-5338 Pharmacy Questions 866-781-7533
Hospitals and Physicians: File claims with your local Blue Cross and/or Blue Shield Plan. Vision: File claims with Davis Vision Dental: File claims with United Concordia File Medicare primary claims with Medicare.	Blue Cross and Blue Shield of Louisiana P.O. Box 98029 Baton Rouge, LA 70898-9029 <small>An independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company. Printed: 07/23/2019</small>
 EXPRESS SCRIPTS*	Pharmacy Benefits Administrator

If you or your dependents need to visit a doctor in person, please consider using your digital ID card instead of your plastic ID card. Digital ID cards are currently available for medical policies only.

Blue Cross and Blue Shield of Louisiana is here to help. Please visit our website at www.bcbsla.com/covid19 for ongoing updates.

Preventative Care Services

We want to help you protect your health and that starts with disease prevention and early detection. If you use a provider in your Blue Card PPO network, you can receive certain routine preventative services at no extra cost to you. This means that visit is not subject to copays or coinsurance, per applicable plan benefits. **It is covered at 100%.** Please see your Health Insurance Department for more information.

	Example of Services
Exams or tests <small>(High-Tech Imaging services such as an MRI, MRA, CT scan, PET scan and nuclear cardiology are not covered under this no-cost preventive benefit but may be covered under other policy benefits. Check your benefit plan.)</small>	<ul style="list-style-type: none"> Routine wellness physical & diagnostic tests such as urinalysis, CBC, cholesterol and glucose Lung cancer screening & tobacco use screening/counseling (adults) Colonoscopy (age 45-75, 1x every 10 years) Women: Routine gynecologist or obstetrician visit
Cancer & other disease screenings	<ul style="list-style-type: none"> Women: Mammography (3D), routine pap smear, BRCA genetic testing, Osteoporosis screening Men: Prostate cancer screening & PSA test
Other screenings & services	<ul style="list-style-type: none"> Blood pressure screening Skin cancer counseling
Immunizations	<ul style="list-style-type: none"> Any immunization recommended by a physician Seasonal flu shots and H1N1 immunizations
Additional Children Benefits	<ul style="list-style-type: none"> Autism screening Developmental & behavioral assessments Anxiety & depression screening Hearing & vision screening Well baby care
Colorectal Cancer Screening	<ul style="list-style-type: none"> Cologuard DNA testing (45-75 years: 1 per benefit period. For more screenings, you pay Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits) Computer tomographic (CT) colonography (45-75 years: 1 every 5 years. For more screenings, you pay Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits) <small>(Cologuard and CT Colonography are noninvasive colorectal cancer screenings used as an alternative to colonoscopies for individuals showing no signs or symptoms and no previous concerning medical history.)</small>

* This is a partial list. The services noted above are paid at 100% for network providers when filed with a wellness code.

Please note: This list is not comprehensive and is subject to change. Some services may have risk, age, time limit or gender limitations.

Preventive Care/Safe Harbor Drugs at \$0 Copay

Preventive Care/Safe Harbor Drugs are drugs that can help keep you from developing a health condition or related complications of a health condition. For the **Blue Saver plan**, the generic preventive care/safe harbor drugs are available at **100% coverage with the deductible waived**, when purchased at an in-network pharmacy. A listing of these drugs can be found at <https://www.bcbsla.com/find-a-doctor/rx-drug-resources>.



Where should I go if I'm sick or injured?

When to Visit Primary Care:

Your primary care doctor is your partner in good health and your main point of contact for your health care needs. Your doctor gives you routine care and will treat you when you have a problem that is not an emergency. You should see your doctor once a year and as needed to help you with ongoing health problems. Your doctor usually can see you during the day Monday through Friday.



Routine Well Visits



Preventative Care



Immunizations or Shots



Diabetes (Sugar)



Rashes



Cold & Flu Symptoms



Colonoscopy



High Blood Pressure



Tooth Pain



Sore Throat



Pink Eye



Lower Back Pain



Animal or Insect Bite



Urinary Tract Infection



Pap Smear

When to Visit Urgent Care:

When your primary care doctor isn't available, or if you are hurt from an injury and you need to see a doctor quickly, urgent care is there to help you. Urgent care can treat any health problem where you need to be seen quickly but is not an emergency. Urgent Care has evening and weekend hours when your primary care doctor may not be available.



Sprains & Strains



Stitches



Rashes



Cold & Flu Symptoms



Tooth Pain



Sore Throat



Pink Eye



Lower Back Pain



Animal or Insect Bite



Urinary Tract Infection

When to Visit the Emergency Room:

You should use the emergency room for any life or death emergency. You should follow up with your primary care doctor after a visit to emergency room.



Allergic Reactions



Babies Needing Immediate Care



Serious Eye or Head Injuries



Severe Burns



Suspected Drug Overdose or Poisoning



Severe Abdominal or Chest Pain



Breathing Problems



Heart Attack Symptoms



High Fevers



Stroke Symptoms

When in doubt, dial 911

Health Savings Account (HSA)

If you enroll in the Low Option medical plan, you're also eligible to open a Health Savings Account (HSA).

The account can be funded with your tax-exempt dollars to help pay for eligible medical expenses not covered by an insurance plan, including the deductible and co-insurance.

Should you choose to participate in the HSA account, Calcasieu Parish School Board will deduct the amount you choose per paycheck and deliver to your HSA account, provided by First Financial.

Please call First Financial for additional information at 866-541-5096.

HSA Benefits

- ✓ All money in the HSA is owned by you.
- ✓ You are not required to spend the savings in a single year.
- ✓ Contributions and interest are tax free.
- ✓ You can change the amount that is deposited in the account from month-to-month.

Tax Benefits

- ✓ Contributions to HSAs are not subject to federal income taxes.
- ✓ Earnings to an HSA from interest and investments are tax-free.
- ✓ Distributions from an HSA to pay for qualified medical expenses are tax-free.

2024 Contribution Limits:

\$4,150 Individual

\$8,300 Family

\$1,000 Catch-up
(Age 55 & older)

Examples of Qualified Expenses

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Breast reconstruction surgery (mastectomy-related)
- Chiropractic services
- Cosmetic surgery (only if due to trauma or disease)
- Dental treatment (X-rays, fillings, braces, extractions, etc.)
- Diagnostic devices (such as blood sugar test kits for diabetics)
- Doctor's office visits and procedures
- Drug addiction treatment
- Eyeglasses, contact lenses and eye exams
- Eye surgery (such as laser eye surgery)
- Fertility enhancements
- Hearing aids (and batteries for use)
- Hospital services
- Laboratory fees
- Long-term care (for medical expenses and premiums)
- Menstrual care products
- Nursing home
- Nursing services
- Operations/surgery (excluding unnecessary cosmetic surgery)
- (Certain) over-the-counter drugs and medications
- Physical therapy
- Prescription medicines or drugs
- Psychiatric care
- Psychologist counseling
- Speech therapy
- Stop-smoking programs
- Vasectomy
- Weight-loss programs (to treat a specific disease diagnosed by a physician)
- Wheelchairs
- X-rays

Example of Non-qualified Expenses

- Advance payment for future medical care
- Amounts reimbursed from any other source (such as other health coverage or a flexible spending account)
- Babysitting, childcare and nursing services for a normal, healthy baby
- Cosmetic surgery (unless due to trauma or disease)
- Diaper services
- Electrolysis or hair removal
- Funeral expenses
- Gasoline expenses to doctor visits
- Health club dues
- Household help
- Massage (unless a prescription is presented)
- Maternity clothes
- Meals
- Nutritional supplements
- Personal-use items (such as toothbrush/toothpaste)
- Swimming lessons
- Teeth whitening



Important Note: Participants in the tax favored health savings account are required to meet certain IRS guidelines to participate. The Blue Saver plans offered are qualified HSA plans. Enrollment in one of these plans should be the only health plan you are covered by in order to make contributions on a tax favored basis. If you are participating in another health plan including Champus or Medicare, please contact your benefits administrator to discuss further or consult your tax advisor.

Calcasieu Parish School Board offers voluntary dental insurance to all full-time eligible employees. Below you will see the benefit features as well as your monthly premium.

Dental Plan		
Plan Features	In-Network	Non-Network*
Reimbursement	Negotiated Fee Schedule	U&C 90 th Percentile
Preventive Services (No deductible; does not apply against annual max)	100%	100%
Basic Services	80% after deductible	80% after deductible
Major Services	50% after deductible	50% after deductible
Deductible • Individual • Family	Basic & Major Services \$50 \$150 Aggregate	Basic & Major Services \$50 \$150 Aggregate
Annual Maximum (Excludes orthodontia services)	\$1,000 + extended annual maximum	
Extended Annual Maximum Additional coverage for preventive, basic, and major services after the annual maximum is met (excludes orthodontia)	30%	30%
Orthodontia Services	Covers <u>children</u> through age 18; Plan pays 50 percent (no deductible) of the covered orthodontia services, up to \$1,000 lifetime orthodontia maximum.	

* Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

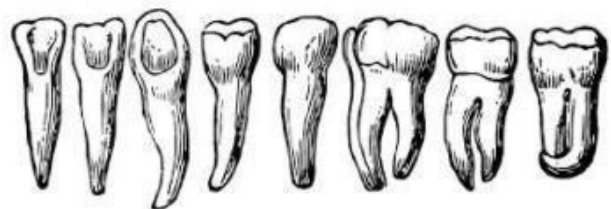
DENTAL PROCEDURES COVERED

Preventive	Routine exams ▪ X-rays ▪ Routine cleanings ▪ Fluoride ▪ Oral Cancer Screening ▪ Sealants ▪ Space maintainers
Basic	Emergency care for pain relief ▪ Amalgam fillings ▪ General anesthesia (in conjunction with covered oral surgical procedure) ▪ Stainless steel crowns ▪ Harmful habit appliances
Major	Oral surgery ▪ Crowns ▪ Inlays/Onlays ▪ Bridges ▪ Dentures ▪ Denture relines/rebases ▪ Denture repair & adjustments ▪ Impants ▪ Periodontics ▪ Endodontics (root canal)

*Policy restrictions, imitations, and waiting periods may apply. Please consult your policy booklet for more information.

DENTAL RATES

Coverage Level	Monthly
Employee Only	\$35.35
Family	\$89.84



Class of Coverage

Class I	Active employees who are employed as Administrators, Supervisors, Assistant Supervisors, Coordinators, Directors, Psychologists, Principals, Assistant Principals, Nurses, Maintenance Foreman, Data Processing Managers, Administrative Interns, Accountants, Auditors, active School Board Members and Programmers.
Class III	Active employees who are employed as Maintenance and Warehouse Personnel, Media Specialists and Electronic Technicians
Class V	Active employees who are employed as Central Office Personnel Staff (other than those in Class I), Unclassified employees, Lunchroom Managers and Assistant Lunchroom Managers
Class VII	Active employees who are employed as Teachers, Counselors, Librarians, Coaches, Secretaries, Clerks, Resource Specialists, Strategists, Teachers Aides, Tutors, Consultants, Assessment Teachers, Consultant Strategists, Social Workers, Evaluation Personnel and Printers
Class IX	Active employees who are employed as Bus Drivers and Bus Driver Aides
Class XI	Active employees who are employed as Cafeteria Workers and Janitors

You have the option to choose additional (optional) life insurance for yourself and your family. Below is a chart (listed by class) showing the cost of the Basic Life, the cost of the Optional Life as well as the cost for both the Basic & Optional Life.

You have the choice of the following amounts:

- A. Basic Amount Only
- Or**
- B. Basic Amount + Optional Amount (for total life coverage amount shown)

Class	Basic Life Coverage Amount	Basic Life Monthly Rate	Optional Life Coverage	Optional Life Monthly Rate	Total Life Coverage Amount	Total Monthly Rates
Class I	\$30,000	\$17.65	\$20,000	\$21.44	\$50,000	\$39.09
Class III	\$20,000	\$10.52	\$15,000	\$10.74	\$35,000	\$21.26
Class V	\$10,000	\$3.35	\$10,000	\$7.16	\$20,000	\$10.51
Class VII	\$10,000	\$3.35	\$15,000	\$10.74	\$25,000	\$14.09
Class IX	\$5,000	\$0.00	\$5,000	\$3.35	\$10,000	\$3.35
Class XI	\$5,000	\$0.00	\$2,000	\$1.20	\$7,000	\$1.20

Dependent Life is paid for by Calcasieu Parish School Board if employee has Basic Life coverage:

- \$1,000 Spouse
- \$100 Children age birth to six months
- \$1,000 Children age six months to age 21 (or 24 if a full-time student and unmarried)

Age reductions are as follows:

- Reduces by 25% at age 65
- Then an additional 25% at age 70

Benefits continue into retirement, subject to terms of the policy.

Calcasieu Parish School Board offers Voluntary Term Life insurance for employees and dependents. The following information provides plan options as well as a monthly premium schedule.

Coverage Options	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI
Employee	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000	\$200,000
Spouse (50% of employee amount, up to \$50,000 maximum)	\$5,000	\$12,500	\$25,000	\$50,000	\$50,000	\$50,000
Children (Age 6 months to 21 years, 24 if full-time student)	\$1,000	\$2,500	\$5,000	\$10,000	\$10,000	\$10,000
Children (Age 14 days to 6 months)	\$500	\$500	\$500	\$500	\$500	\$500

- Retirees are eligible to continue coverage after retirement. Retiree must be eligible as a Retiree under his/her specific retirement system.
- Retirees are not eligible for total and permanent disability waiver of premium.
- Maximum Benefit available for Retirees is \$50,000 with Spouse limited to 50% of Retiree benefit to a maximum of \$25,000.
- **All coverage terminates at age 70**
- Total and permanent disability of the Employee allows coverage to be extended until 70 or until recovered without premium payment for the employee benefits.
- Continuation of coverage and conversion privilege are available for both Employee and Dependents.
- Dependents who are hospitalized or unable to perform the normal duties of a person of like age on the proposed effective date for increased coverage, will not become effective and existing coverage may not be increased until the Dependent is released from the hospital by the attending physician and actually does his/her normal duties.
- Evidence of Insurability is required on amounts in excess of \$50,000 (during scheduled open enrollment).

VOLUNTARY GUARANTEE ISSUE

OPEN ENROLLMENT PERIOD: All new employees actively at work on the effective date of coverage will be guaranteed issued \$50,000.

The open enrollment for new employees will only apply to the first 30 days of employment.

VOLUNTARY LIFE MONTHLY PREMIUM SCHEDULE

Age	PLAN I		PLAN II		PLAN III		PLAN IV		PLAN V		PLAN VI	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Under 30	\$0.50	\$ 1.20	\$ 1.25	\$ 3.00	\$ 2.50	\$ 6.00	\$ 5.00	\$ 12.00	\$ 7.50	\$ 14.50	\$ 10.00	\$ 17.00
30 – 39	\$0.70	\$ 1.70	\$ 1.75	\$ 4.25	\$ 3.50	\$ 8.50	\$ 7.00	\$ 17.00	\$ 10.50	\$ 20.50	\$ 14.00	\$ 24.00
40 – 44	\$1.20	\$ 2.40	\$ 3.00	\$ 6.00	\$ 6.00	\$12.00	\$ 12.00	\$ 24.00	\$ 18.00	\$ 30.00	\$ 24.00	\$ 36.00
45 – 49	\$1.70	\$ 3.30	\$ 4.25	\$ 8.25	\$ 8.50	\$16.50	\$ 17.00	\$ 33.00	\$ 25.50	\$ 41.50	\$ 34.00	\$ 50.00
50 – 54	\$2.70	\$ 5.10	\$ 6.75	\$12.75	\$13.50	\$25.50	\$ 27.00	\$ 51.00	\$ 40.50	\$ 64.50	\$ 54.00	\$ 78.00
55 – 59	\$4.40	\$ 7.80	\$11.00	\$19.50	\$22.00	\$39.00	\$ 44.00	\$ 78.00	\$ 66.00	\$100.00	\$ 88.00	\$122.00
60 – 64	\$6.10	\$10.50	\$15.25	\$26.25	\$30.50	\$52.50	\$ 61.00	\$105.00	\$ 91.50	\$135.50	\$122.00	\$166.00
65 – 69	\$8.30	\$14.20	\$20.75	\$35.50	\$41.50	\$71.00	\$ 83.00	\$142.00	\$124.50	\$183.50	\$166.00	\$225.00

- Age changes will occur on September 1, each year for individuals entering new age brackets.



Supplemental Accidental Death & Dismemberment

To elect this coverage, find your class & amount and check the corresponding boxes on the enrollment form under: Employee Basic Life, Spouse Basic Life, Child(ren) Basic Life and Optional Employee Life.

All full-time active employees are eligible to enroll in Supplemental Accidental Death & Dismemberment insurance. There is no age limit for the employee but the policy age limit for a spouse is 70.

Principal Sum Amount has a minimum of \$10,000 and a maximum of \$250,000 in \$10,000 increments. For amounts above \$150,000, the principal sum requested cannot exceed the lesser of 10 times your earnings or the maximum above.

Age reductions are as follows:

<u>Your age:</u>	<u>Percentage of Principal Sum:</u>	
Ages 70-74	65%	• These reductions also apply if you become covered the policy or your coverage increases on or after the date you attain age 70.
Ages 75-79	45%	
Ages 80-84	30%	• This benefit is payable to you or your covered dependents, when you sustain an injury that results in any of the following losses within 365 days of the date of the accident:
Ages 85+	15%	

For Loss of:	Benefit:
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Loss means with regard to:

1. Hands and feet, actual severance through or above wrist or ankle joints;
2. Sight, speech and hearing, entire and irrecoverable loss thereof;
3. Thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4. Movement, complete and irreversible paralysis of such limbs.

Principal Sum for each of your eligible dependents

Principal Sum	Spouse	Each Dependent Child
Spouse Only	50%	0%
Spouse & Dependent Child(ren)	40%	10%
Dependent Child(ren) Only	0%	15%

Principal Sum for any one Child cannot exceed the lesser of the amount calculated above or \$50,000.

Monthly Deductions

Principal Sum	Employee Only Plan	Family Plan
\$10,000	\$0.34	\$0.50
\$20,000	\$0.68	\$1.00
\$30,000	\$1.02	\$1.50
\$40,000	\$1.36	\$2.00
\$50,000	\$1.70	\$2.50
\$60,000	\$2.04	\$3.00
\$70,000	\$2.38	\$3.50
\$80,000	\$2.72	\$4.00
\$90,000	\$3.06	\$4.50
\$100,000	\$3.40	\$5.00
\$110,000	\$3.74	\$5.50
\$120,000	\$4.08	\$6.00
\$140,000	\$4.76	\$7.00
\$150,000	\$5.10	\$7.50
\$160,000	\$5.44	\$8.00
\$170,000	\$5.78	\$8.50
\$180,000	\$6.12	\$9.00
\$190,000	\$6.46	\$9.50
\$200,000	\$6.80	\$10.00
\$210,000	\$7.14	\$10.50
\$220,000	\$7.48	\$11.00
\$230,000	\$7.82	\$11.50
\$240,000	\$8.16	\$12.00
\$250,000	\$8.50	\$12.50



I have been informed that if I choose to participate in the group health insurance plan upon my retirement, the premium will be subjected to the following structure and is based on **Years of Participation*** in the health insurance plan. **Please Note** – Employee's years of participation do not include years as a dependent child.

I also have been informed that it is my responsibility to add any new dependents and cancel any ineligible dependents from my insurance policies within 30 days of their eligibility/ineligibility by the employee visiting the health insurance office and providing the appropriate documentation.

<u>Retirees</u>	<u>Years of Participation*</u>	<u>Employer Contribution</u>
	Less than 1 year	0%
	At least 1 year, but less than 10 years	16%
	At least 10 years, but less than 15 years	32%
	At least 15 years, but less than 20 years	47%
	20 years or more	62%
<u>Dependents</u>	<u>Years of Participation*</u>	<u>Employer Contribution</u>
	Less than 1 year	0%
	At least 1 year, but less than 10 years	12%
	At least 10 years, but less than 15 years	25%
	At least 15 years, but less than 20 years	38%
	20 years or more	50%

IMPORTANT NOTICES

Special Enrollment under HIPAA—certain events that happen to employees or their dependents trigger a right to “special enroll” in your employer-sponsored group health plan. Special enrollment generally means that the employee or dependent will have 30 days from the date of the event to request coverage in your group health plan, regardless of your open enrollment period. Special enrollment rights under HIPAA arise out of:

- o The loss of other health coverage; or an employer terminating contributions toward health coverage.
- o A person becoming a new dependent through marriage, birth, adoption or placement for adoption.

Loss of other health coverage—to have a special enrollment opportunity as a result of losing other health coverage:

- o You or your dependent must have had other coverage when you previously declined coverage under the group health plan.
- o If the coverage was COBRA continuation, special enrollment can be requested only after the COBRA continuation coverage is exhausted.
- o If the other coverage was not COBRA continuation coverage, special enrollment can be requested when you lose eligibility of the other coverage.

Examples of events related to losing health coverage include divorce or legal separation, dependent no longer eligible due to age, death of employee covered by the plan, termination of employment, reduction in hours of employment, plan no longer offers benefits, etc.

30 days to request special enrollment—the plan must provide at least 30 days to request coverage after the loss of other coverage or termination of employer contributions.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse’s employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name
Address
City, State, Zip
Telephone
Email Address

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Each year, the open enrollment period for health insurance coverage through the Marketplace runs from November 1st through December 15th of the previous year. Individuals must enroll or change plans prior to December 15th for coverage starting as early as January 1st. After December 15th, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children’s Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted annually) of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employer contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

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

IMPORTANT NOTICE FROM ABOUT YOUR PRESCRIPTION DRUG COVERAGE & 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 _____ 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. _____ has determined that the prescription drug coverage offered by _____ Health Group Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 _____ coverage will be affected. See plan SPD for more information about your prescription drug coverage provisions/options. If you do decide to join a Medicare drug plan and drop your current _____ 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 _____ 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 _____ 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).

Name of Entity/Sender:

Address

City, State, Zip

Telephone

Email Address

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

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-KIDSNOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	FLORIDA – Medicaid Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268
COLORADO – Health First Colorado (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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	GEORGIA – Medicaid A 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
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	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	MONTANA – Medicaid Website: http://dphs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	NEVADA – Medicaid Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – 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	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	NEW JERSEY – Medicaid and CHIP 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
MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – 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	NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlts Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024 or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

DISCLAIMER

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

WHO TO CONTACT

Blue Cross Blue Shield of LA	 Louisiana	www.bcbsla.com	1-800-599-2583
Express Scripts (BCBS Pharmacy Network)	 EXPRESS SCRIPTS®	www.express-scripts.com	1-866-781-7533
First Financial HSA Banking & Supplemental Plans	 First Financial Group of America	www.ffga.com	1-866-541-5096
Humana Dental	 Humana	www.humana.com	1-800-233-4013
Trustmark	 Trustmark	www.trustmarkbenefits.com	1-337-217-4240 X3009
The Hartford	 THE HARTFORD	www.thehartford.com	1-337-217-4240 X3009

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If you have any questions about this summary, contact Human Resources.

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