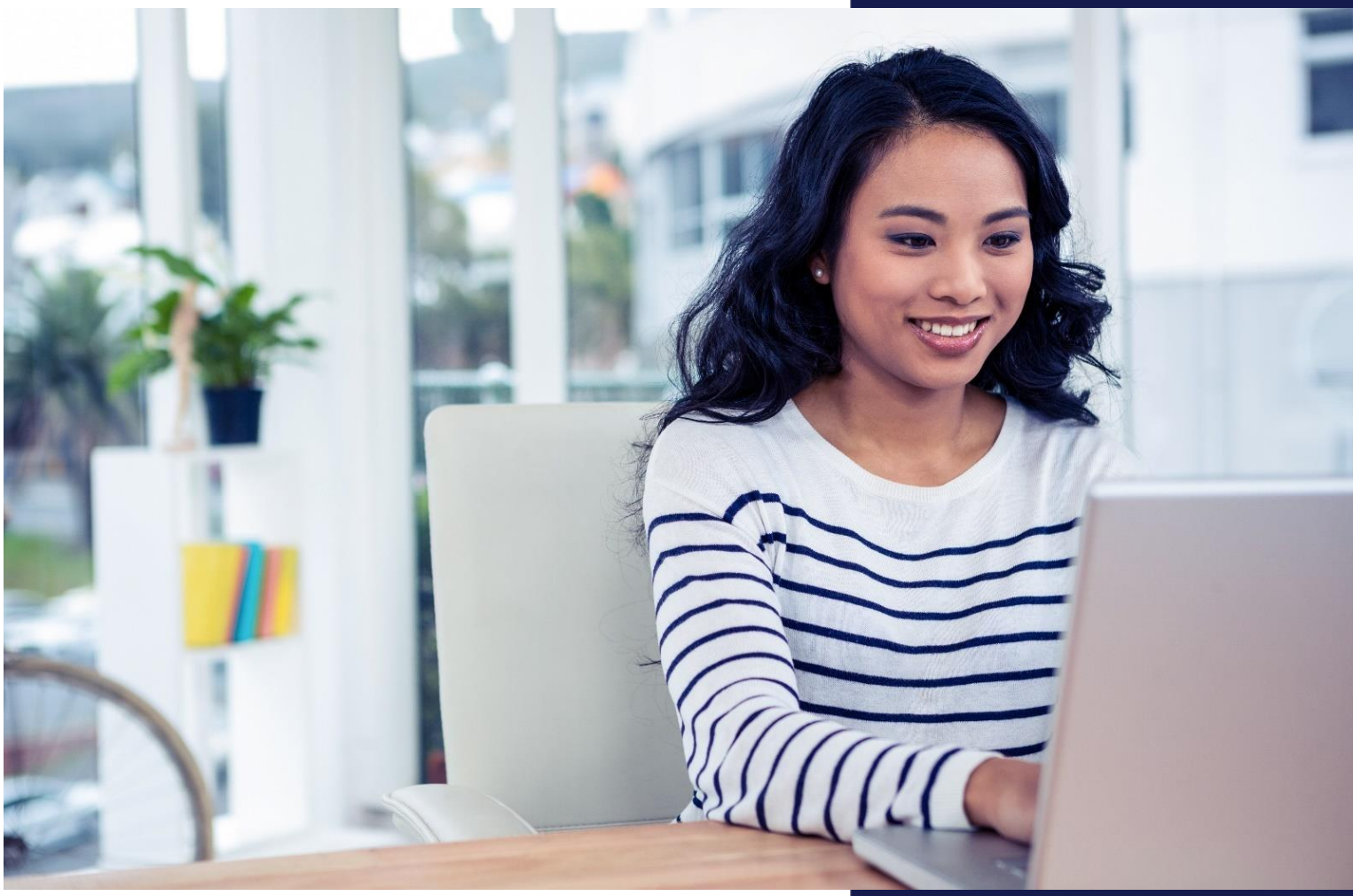
USD 261 HAYSVILLE SCHOOLS



2026 - 2027 BENEFITS OVERVIEW

Haysville USD 261 School District

Open Enrollment: July 31st – August 14th
Plan Year: October 1, 2026 - September 30, 2027

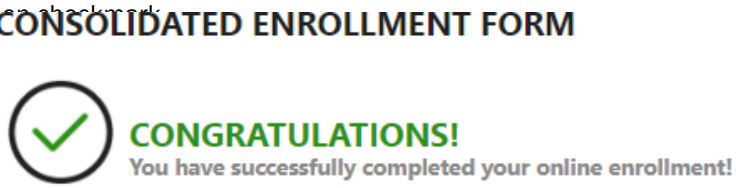
Contacts

VENDORS	WEBSITE	PHONE
Blue Cross Blue Shield of KS *Medical & Rx*	www.bcbsks.com	800-432-3990
Amwell (BCBSKS) *Telehealth*	www.bcbsks.com/health-and-wellness/telehealth	844-733-3627
Delta Dental *Dental*	www.deltadentalks.com	800-234-3375
Surency Life and Health *Vision*	www.surency.com	866-818-8805
National Benefit Services *Flexible Spending Account(s)*	https://nbs.wealthcareportal.com/Page/Home	800-274-0503
Standard *Life/AD&D, Disability, Accident, Critical Illness & Hospital Indemnity* *Health Advocate EAP*	www.standard.com EAP: healthadvocate.com/Standard3	800-628-8600 888-293-6948
KPERS	www.kpers.org	888-275-5737
BENEFITS SPECIALIST	**CONTACT**	**PHONE**
Brown & Brown	Janine McClung | Janine.mcclung@bbrown.com Nancy Conard | Nancy.conard@bbrown.com	816-843-4479 816-631-0750
USD 261 RESOURCES	**CONTACT**	**PHONE**
Benefits Office	Jaclyn Evans | jevans@usd261.com	316-554-2200
403(B) VENDORS	**CONTACT**	**PHONE**
American Fidelity Assurance	American Fidelity Assurance	800-662-1106
Ameriprise Financial Services	Ameriprise Financial Services	800-297-7348
AXA Equitable Life Insurance	William Benjamin | william.benjamin@equitable.com Cole Johnson | cole.johnson@equitable.com Brandon McBeth | brandon.mcbeth@equitable.com	316-308-6118 316-648-2351 316-208-6130
Brighthouse Life Insurance	Brighthouse Life Insurance Co.	800-638-7732
Fiduciary Trust of NH	Fiduciary Trust Co. of New Hampshire	877-500-9590
Horace Mann Life Insurance	Rod Myers | rod.myers@horacemann.com	316-788-2894
Metropolitan Life Insurance	James Flores | jflores2@metlife.com	316-461-5623
National Life Group	Jann Newton Jnewton912@gmail.com Doug Hodgens dhholdingsllc@gmail.com	
PCS Retirement-Aspire	Jeffrey Bachelder | bachelderj@ceteranetworks.com Gavin Scheer | gavin.scheer@edwardjones.com	316-258-9405 316-729-4377
Reliastar / ING	Shawn Kuntz | shawnkuntz@sbcglobal.net Christopher Robrahn | christopherrobrahn@legendequities.com	316-788-7884 316-733-8250
Security Benefit Life	Leasha Rutschman | leasharutschman@ofgfinancial.com Ginger Hamilton | gingerhamilton@ofgfinancial.com Ian Lindstrom | ianlindstrom@ofgfinancial.com	316-461-5063 316-670-0049 316-990-8923
Voya Retirement & Annuity-Ease	Voya Retirement Ins. & Annuity	888-410-9482
457 VENDORS	**CONTACT**	**PHONE**
Security Benefit Life	Wayne Hamilton Leasha Rutschman Ginger Hamilton	800-281-0538 316-461-5063 316-670-0049
Empower	Empower Customer Service	855-756-4738

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You can find a detailed overview of the login process by visiting the **THE*benefits*HUB** Employee Benefits Portal Quick Links section or by scanning or clicking the QR code here or visit THEbenefitsHUB at mybenefitshub.com/usd261.

You should continue through the entire enrollment process to the end, which will be evident when you reach the Consolidated Enrollment Form screen marked with a green checkmark.



WHEN TO ENROLL

Online open enrollment will be available for access July 31 — August 14, 2026. All employees must login to **THE*benefits*HUB** to complete enrollment or waive coverage by August 14, 2026 (11:59 pm). **If you are currently enrolled and do not complete enrollment for the new plan year, your coverage will terminate.** Once you have made your elections you will **not** be able to change them until the next open enrollment period unless you experience a qualified life event.

WHEN DOES COVERAGE BECOME EFFECTIVE?

Open Enrollment Elections and August New Hires

- All benefits are effective October 1, 2026 — September 30, 2027

Elections for Employees Hired AFTER Open Enrollment (Hired September — July)

- Enrollment/declination on **THE*benefits*HUB** is required within 30 days from date of hire/eligibility
- Benefits elected are effective the first of the month following your date of hire
- You may be subject to double deductions and the Hub costs may be inaccurate, as they are based on those hired before the start of the school year. Please reach out if you would like further information.

click the link to access an audio-visual presentation of the benefit changes:
https://www.brainshark.com/bbbrown/vu?pi=zlyz17icGYzkeLrz0



SCAN ME

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BENEFIT CHANGES

Can I make changes outside Open Enrollment?

Benefit contributions are made on a tax-exempt basis, and IRS regulations state that you cannot change your tax-exempt benefit options during the year unless you have a qualified life event. Qualified life events include:

- Change in legal marital status (marriage, divorce, legal separation)
- Change in dependents (birth, adoption, legal guardianship, or if a child is no longer an eligible dependent)
- Change in dependent status (your child turns 26)
- Change in your Spouse's employment status (resulting in gain or loss of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time
- Entitlement, or loss of, Medicare or Medicaid
- Termination of COBRA Continuation Coverage or exhaustion of coverage

Visit the Benefits Google Drive for procedures and forms to make changes mid - year.

SCAN ME

Any changes resulting from a qualifying event must be reported and documented within 30 days. It is YOUR responsibility to notify and submit applicable change forms to capture such changes. Only benefit changes consistent with a qualified life event are permitted outside of the Open Enrollment period.

QUALIFIED LIFE EVENT		DOCUMENTATION TO SUBMIT
Dependent loss of the state's CHIP plan	>>	A copy of the Certificate of Creditable Coverage or a termination letter which lists the date coverage ended
Judgement, decree or court order to add coverage for a dependent child	>>	A copy of the court order awarding custody or requiring coverage
Legal marriage	>>	Marriage certificate or Affidavit of Common Law Marriage
Birth / Adoption	>>	Birth or hospital certificate / Adoption decree or certificate
Death of your spouse or dependent	>>	A copy of the death certificate
Change in employment status	>>	Certificate of Creditable Coverage, COBRA notice or a termination letter which lists the date coverage ended

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Medical Benefits

Medical Plan(s) At-A-Glance

IN-NETWORK COVERAGE	PPO OPTION 1	PPO OPTION 2	HDHP OPTION 3
BENEFIT ACCUMULATION PERIOD: OCTOBER 1, 2026 - SEPTEMBER 30, 2027			
Plan Year Deductible Individual / Two-or-more Persons	$1,000 / $2,000	$2,000 / $4,000	$ 5,000 / $10,000
Coinsurance	50%		70%
Plan Year Maximum Out-of-Pocket Individual / Two-or-more Persons (includes deductible/copays/coinsurance)	$7,000/ $14,000		$6,350 / $12,700
DOCTOR'S OFFICE VISITS			
Home & Office Visits	$30 copay		Deductible/coinsurance
Specialty	$70 copay		
Preventive Care (defined by ACA)	Paid at 100% of the allowable charge		Paid at 100% of allowable charge
MEDICAL SERVICES			
Emergency Room	$300 copay; then deductible/coinsurance		Deductible/coinsurance
Emergency Medical Transportation	Deductible/coinsurance		Deductible/coinsurance
Urgent Care	$30 Copay		Deductible/coinsurance
Inpatient Facility Fee	Deductible/coinsurance		Deductible/coinsurance
OP Surgery Physician/Surgical	Deductible/coinsurance		Deductible/coinsurance
OP Lab, Radiology & Advanced Imaging	Pays 100% to a combined maximum of $300 per person, each benefit period; then deductible/coinsurance		Deductible/coinsurance
Accidental Injury Services	Deductible/coinsurance		Deductible/coinsurance
DRUG COVERAGE (BlueRx Card)			
Prescription Drugs & Mail Order (generic, formulary, non-formulary, specialty*) *Mandatory Generics* **Designated Specialty Pharmacy*	$15 / 40% ($50 min) / 60% ($75 min) / 50% ($150 min); Mail order is 2 1/2x copay	$125 / $250 Rx deductible, Then 50%; Mail order is subject to retail deductible/ coinsurance.	Deductible then $15 / $50 / $75 / $75* / 50% ($300 min)
RECOVERY & SPECIAL NEEDS			
Outpatient Rehabilitation	Deductible/coinsurance		Deductible/coinsurance
Hospice	Deductible/coinsurance		Deductible/coinsurance
Home Social Work Visits	Deductible/coinsurance		Deductible/coinsurance
MENTAL & BEHAVIORAL HEALTH			
Inpatient	Deductible/coinsurance		Deductible/coinsurance
Outpatient	$30 office visit copay		Deductible/coinsurance

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Medical Payroll Contributions

PPO Option 1	District Contribution	Certified Monthly	Classified 10-Month (19 Payrolls)	Classified 12-Month (26 Payrolls)	Total Premium
Employee	$500.00	$345.64	$218.30	$159.53	$845.64
Employee + 1	$600.00	$868.04	$548.24	$400.63	$1,468.04
Family	$1,150.00	$1,201.58	$758.89	$554.58	$2,351.58
PPO Option 2	**District Contribution**	**Certified Monthly**	**Classified 10-Month (19 Payrolls)**	**Classified 12-Month (26 Payrolls)**	**Total Premium**
Employee	$500.00	$293.56	$185.41	$135.49	$793.56
Employee + 1	$600.00	$777.50	$491.05	$358.85	$1,377.50
Family	$1,150.00	$1,056.48	$667.25	$487.61	$2,206.48
HDHP Option 3	**District Contribution**	**Certified Monthly**	**Classified 10-Month (19 Payrolls)**	**Classified 12-Month (26 Payrolls)**	**Total Premium**
Employee	$500.00	$196.02	$123.80	$90.47	$696.02
Employee + 1	$600.00	$607.88	$383.92	$280.56	$1,207.88
Family	$1,150.00	$784.52	$495.49	$362.09	$1,943.52

Note about 10-Month Classified Employees, Coverage, and Summer Deductions:

- Ten-month employees continue to receive benefit coverage during the summer months, even though they do not receive paychecks during that time; therefore, summer benefit premiums are collected throughout the school year to ensure continuous, uninterrupted coverage.
- Employees hired mid-year also receive summer coverage, but because fewer paychecks remain in the school year to collect these premiums, their payroll deductions may be higher to ensure full payment before summer break. Additionally, HUB payroll calculations will not be accurate for mid-hire employees, as summer deductions must be calculated manually based on the number of remaining pay periods at the time of enrollment.

A NOTE ABOUT PREVENTIVE CARE

Preventive care services are generally linked to annual wellness exams. Non-preventive services are those services that are considered treatment or diagnostic for an illness, injury or other medical condition. There may be limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care or refer to www.healthcare.gov/preventive-care-benefits/.

FIND A PROVIDER

You have the freedom to use the doctor or hospital of your choice. However, maximum benefits are available when services are received from in-network providers. Blue Choice is the name of the provider network. To verify if a provider is an in-network provider, visit bcbsks.com **> Find a Doctor/Hospital > Choose Blue Choice Preferred-Care Blue Network.**

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Value Added Benefits

BCBSKS HEALTH & WELLNESS

As an added bonus with your Blue Cross Blue Shield coverage, you have access to these great wellness programs. **Healthy**Options™ offers interactive tools and health and wellness resources to help you take charge of your health and enjoy your life.

Blue365		Exclusive to Blue Cross members, you have access to weekly deals and discounts related to fitness and healthy eating.
WebMD Health Assessment		Your resource for unlimited access to doctor-designed, powerful online tools, including a personalized health risk assessment and more
Case Management		Assistance with coordination of services and benefits for your complex medical conditions
Disease Management		Our registered nurses serve as coaches to help you manage your asthma, COPD, diabetes, heart disease, high blood pressure and high cholesterol
Wellness Management		Our registered nurses will provide you with the tools you need to manage stress, become tobacco-free or lose weight
Behavioral Health		Help for anxiety, depression, and other behavioral health issues is just a few clicks away
Wellness Media Library		Review videos, webinars, timely articles and more to help you live your best life

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TELEHEALTH

With Blue Cross and Blue Shield of Kansas (BCBSKS) coverage, you can have a live visit on your computer or mobile device with a doctor at a time that works for you. Blue Cross provides telehealth services through American Well® (Amwell). With Amwell, registration is **FREE**, and the cost per visit is less than an emergency room visit. It's easy to use, affordable, private and secure.

HOW TO USE AMWELL?

1. Download the Amwell app on any mobile device.
2. On a computer? Visit www.amwell.com to get started.





HOW TO DOWNLOAD THE APP FOR YOUR SMART PHONE?

Follow these steps to connect with Amwell through the app:

- Grab your BCBSKS ID card and have your medical history nearby, as you'll need certain information to use Amwell.
- Search for and download the Amwell app from the Apple Store (if you have an apple device) or from Google Play Store (if you have an Android device).
- Install the app – you open the app by finding the icon on your device that looks like a heart with a checkmark in it.
- Open the app and register for your virtual visit in order to access benefits through your health plan (self-pay options are also available through Amwell).
- Select Blue Cross and Blue Shield of Kansas from the drop-down menu in the health plan field.
- When prompted, enter your Subscriber ID from your BCBSKS ID Card.
- When prompted select the type of service you want.
- Next, you'll see a list of providers available to you. Select the provider you'd like to see or simply wait for the next available provider.
- You will next need to answer some questions about the problem for which you're seeking care and some general information about your health status and history.
- That's it! You'll next watch a short Amwell welcome video and go to the virtual "waiting room" for your provider.
- If you can't wait, you can also schedule an appointment for a time that is convenient for you.

WHY USE AMWELL?

- Choose your own physician for your visit from a list of U.S. board-certified doctor and therapist profiles
- Available nationwide, 24/7/365
- All prescriptions can be conveniently picked up at your local pharmacy.
- Easy payment for the visit with credit, debit or HSA/FSA cards.
- A complete record of each visit is securely maintained and can be accessed by the patient.

HOW MUCH DOES AMWELL COST?

The out-of-pocket cost of an Amwell doctor or therapist visit depends on your plan type. Doctor visits on Amwell are **$0** for employees enrolled in PPO Option 1 or Option 2, and **subject to your deductible** for employees enrolled in the High-Deductible Health Plan (HDHP) Option 3. Other covered services include consultation visits with a dietician, social worker, behavioral health professional and psychiatrist at their respective costs.

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Dental Benefits

Dental Plan(s) At-A-Glance

Dental benefits are offered through **Delta Dental of Kansas.** When you receive services from an in-network provider, you receive discounts on your dental care, meaning you save money on your portion of the cost of services, and your annual maximum goes further. To locate a dentist in-network, download the Delta Dental mobile app, visit www.deltadentalks.com or call customer service at **800-234-3375.**

COVERED SERVICES	IN-NETWORK BENEFIT
BENEFIT ACCUMULATION PERIOD: OCTOBER 1, 2026 - SEPTEMBER 30, 2027	
Plan Year Deductible (Individual/Family)	$25/$75
Plan Year Maximum (Per Covered Person)	$1,500
Diagnostic & Preventive Care • Oral evaluations - twice per calendar year • Bitewing x-rays - twice per calendar year for dependents under age 18; once every 12 months for adults age 18 and over • Full mouth or panoramic x-rays - once every 5 years • Unlimited Cleanings • Topical fluoride - twice per calendar year for dependents under age 19 • Space Maintainers - for dependents under age 14 • Sealants - once per tooth, per lifetime for dependents underage 16	Covered at 100%
Basic Services (subject to deductible) • Ancillary - 1 emergency exam per benefit period for relief of pain • Oral surgery - includes pre & post-operative care • Fillings • Periodontics • Endodontics - root canal treatments and root canal fillings	Covered at 80%
Major Services (subject to deductible) • Bridges - including repairs & adjustments • Crowns • Partial and complete dentures	Covered at 50%
RIGHT START 4 KIDS Children, **age 12 and under**, receive coverage at 100% for all services covered under the plan. Not subject to deductible, but the plan's annual maximum and frequencies/limitations apply. Excludes orthodontics. Must see an in-network provider or the plan's underlying contract applies including deductibles and coinsurance levels.	**Covered at 100%**

Dental Payroll Contributions

Coverage Tier	District Contribution	Certified Monthly	Classified 10-Month (19 Payrolls)	Classified 12-Month (26 Payrolls)	Total Premium
Employee	$36.19	$0.00	$0.00	$0.00	$36.19
Family	$36.19	$65.96	$41.66	$30.44	$102.15

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MANAGING MY BENEFITS

At deltadentalks.com, you can log in to your member account to:

- Print ID cards
- Check your eligibility, benefit information, and claim status
- Sign-up to receive your Explanation of Benefits electronically

Through Delta Dental's mobile app, you can:

- Find a dentist and schedule an appointment
- Utilize the Dental Care Cost Estimator
- Check your coverage and claims

DENTAL CARE COST ESTIMATOR

Find out what to expect to pay at an upcoming dental appointment with our Dental Care Cost Estimator*. This easy-to-use tool provides estimated out-of-pocket costs based on the selected dentist and the individual's specific dental plan! Use the Dental Care Cost Estimator on the Delta Dental mobile app or online through your member account.

Here's How it Works:

1. **Log in** to the Delta Dental mobile app or your online member account at deltadentalks.com
2. Once logged in, select the **Dental Care Cost Estimator** tool.
3. **Fill out the form**—select who the estimate is for, your zip code, the treatment you would like to look up and your dentist. To find your dentist, start typing in their last name, and then tap the search button to the right and select your dentist. When finished, select **Get Cost Estimate**.
4. You will see a screen that will show you **Your Responsibility**. You will also see if your deductible is applied, and how much of your maximum is remaining.



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Voluntary Vision Benefits

Vision Plan At-A-Glance

USD 261 offers vision coverage through Surency Vision. **Vision care services are available once every 12 months** and are computed by date of service, not calendar year.

Covered Services	In-Network Member Cost	Out-of-Network Allowances
Vision Exam (with dilation as necessary) Retinal Imaging	$10 $39	$35
Frames	$130 Allowance	$65
Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular	 $10 copay $10 copay $10 copay $10 copay	 $25 $40 $55 $55
Lens Options Standard polycarbonate UV Coating Tint (solid & gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (add-on to bifocal) Premium Progressive (add-on to bifocal) Other Add-Ons & Services	 Adults: $40 / Dependents <19: $0 $15 $15 $15 $45 $65 $65 + 80% of retail less $120 20% off Retail Price	 $25 Not covered Not covered Not covered $40 $40 Not covered Not covered
Contact Lens Fit & Follow Up Contact lens fit & 2 follow-up visits are available once a vision exam has been completed) Standard Premium (e.g. toric, multifocal, etc.)	 $0 10% off retail; then apply $55 Allowance	 $40 $40
Contact Lenses (Allowance is not available if eyeglass lenses are elected) Conventional Disposable Medically Necessary	 $130 allowance, 15% off balance $130 allowance $0	 $100 $100 $200

Vision Payroll Contributions

Coverage Tier	Certified Monthly	Classified 10-Month (19 Payrolls)	Classified 12-Month (26 Payrolls)	Total Premium
Employee	$8.13	$5.13	$3.75	$8.13
Employee + Spouse	$17.08	$10.79	$7.88	$17.08
Employee + Child(ren)	$14.63	$9.24	$6.75	$14.63
Family	$28.46	$17.97	$13.14	$28.46

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HOW TO FIND AN IN-NETWORK PROVIDER

Surency Vision is proud to collaborate with EyeMed. EyeMed has a large, diverse network with retail chains and independent private practitioners that offer quality, convenience, and choice. Your vision plan uses the "**Eyemed Access Network**". You can locate a provider at www.surency.com or download the Surency Vision mobile app (available for Apple or Android).

MOBILE APP FEATURES

To download the mobile app, search the Apple App Store or Google Play for "Surency Vision".

- Finding a doctor
- Check your eligibility and claim status
- Order replacement contact lenses
- Access your mobile ID card

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Flexible Spending Account (FSA)

A Flexible Spending Account (FSA), also known as a reimbursement account, allows you to pay for a variety of out-of-pocket health care and dependent care expenses pre-tax. Putting money into an FSA before you pay taxes on it saves you money by lowering your taxable income. The result? **You pay less in taxes each year.**

To participate in a Flexible Spending Account, you must actively re-enroll each year by making an annual contribution election during open enrollment, or when first eligible. Plan carefully when deciding how much you want to contribute to your account(s) for the year. Once you elect a contribution amount, you cannot change that amount during the plan year unless you experience a qualified change in status.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Set aside pre-tax dollars from your paycheck to cover eligible health care expenses such as eyeglasses, contacts, copays, deductibles, prescription medications, and orthodontia. The entire amount you set aside is available to use on the first day of your coverage effective date. Refer to **IRS Publication 502** for a list of eligible expenses.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Set aside pre-tax dollars from your paycheck to cover eligible dependent care expenses such as day care, babysitting and general purpose day camps for your dependents under the age of 13 while you are at work. You can also use the funds to pay for adult day care services for dependent adults who are unable to care for themselves. You will be reimbursed for eligible expenses as they are incurred and as funds are deposited into your account. Refer to **IRS Publication 502** for a list of eligible expenses.

FSA 2026 PLAN LIMITS	HEALTH CARE FSA	DEPENDENT CARE FSA
Annual Maximum	$3,400	$7,500*

**Dependent Care FSA: $2,500 if married and filing separately*

IMPORTANT REMINDERS

- **Funds will be available October 1, 2026**
- **Eligible expenses must be incurred between october 1, 2026 - September 30, 2027**
- The FSA Health Care Account allows a 2 1/2-month grace period to incur eligible health care expenses. All claims must be submitted by **November 14, 2027,** in order to receive reimbursement. Any unused amounts after the grace period will be forfeited.

The convenient NBS Benefits Card allows you to avoid out-of-pocket expenses, cumbersome claim forms and reimbursement delays. Your card is good for three years from date of issue and will be reloaded annually with your elected amount. Or you may also utilize the “pay a provider” option on the NBS web portal. There is a mandatory monthly service fee of $3.10.

NBS MOBILE APP

- √ Scan product barcodes to instantly determine product eligibly of over-the-counter products
- √ Snap a photo of receipts within the app to submit with new or existing claims
- √ Access FSA Store® to view and purchase eligible items
- √ Submit claims for Health Care FSA and Dependent Care FSA expenses
- √ View account information, notifications and alerts
- √ Report benefit card lost or stolen
- √ Order new benefit cards

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Health Savings Account (HSA)

A Health Savings Account (HSA) is a plan designed to help you manage the rising cost of health care by allowing you to set aside money to pay for out-of-pocket medical expenses and to save for retirement. You can think of it as a personal savings account for medical expenses. HSAs are employee-owned, meaning you take the HSA with you if you change employers. Unused funds will earn interest and can be invested until they are withdrawn for eligible expenses or at retirement. You set aside money on a pre-tax basis, this means as long as you use the money for eligible expenses, you won't pay income taxes on it.

ELIGIBILITY REQUIREMENTS

- You are covered by a Qualified High-Deductible Health Plan (HDHP Option 3)
- You are not covered under another medical plan that is not an HDHP
- You are not enrolled in Medicare benefits
- You cannot be claimed on another person's tax return
- You have not received VA benefits in the last three months
- You are not participating in a **healthcare** FSA through USD 261 or any other **healthcare** FSA (i.e., spouse's healthcare FSA)

PARTICIPATING IN A HSA IS EASY

Once you've enrolled and set your annual election amount, that amount will be automatically taken out of your paychecks in equal increments throughout the year before you pay federal, state, and FICA taxes on that amount of income. Post-tax contributions can also be made as long as they do not surpass the annual max for that year.

Any unused funds in your HSA will roll over at the end of the year and will continue to earn interest and can be invested until they are withdrawn for medical expenses or until you turn 65 years old, when you can withdraw funds for any reason without incurring tax penalties.

HSA 2026 ANNUAL CONTRIBUTIONS*	INDIVIDUAL	FAMILY
Annual Contribution Maximum	$4,400 *($4,500 in 2027)*	$8,750 *($9,000 in 2027)*
Employee Catch-Up Contribution *(over age 55)*	$1,000	$1,000

*Contribution amount based on employee working **and** enrolled in an HSA eligible medical plan through **October 1, 2026 — September 30, 2027**. The monthly administration fee of $2.05 will be pay roll deducted.

WHEN DO I USE MY HSA?

Debit cards are provided for employees to easily access HSA funds. After visiting a physician, facility or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles, coinsurance, and copays) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense.



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Ancillary Benefits

Basic Life/AD&D Insurance

USD 261 provides eligible employees with basic term life coverage at **no cost to you**. The benefit is equal to 1 1/2 times your base annual earnings to a maximum of $250,000. Enrollment is automatic through KPERS.

SUPPLEMENTAL LIFE INSURANCE

USD 261 offers supplemental life insurance administered by The Standard. You must be enrolled in order to elect coverage for your dependents. Below is a brief summary of coverage options.

Employee Coverage

> $10,000 to 6x annual salary or $500,000, whichever is less
> Purchased in increments of $10,000
> Guaranteed Issue* at initial opportunity is $200,000
> Coverage amount reduces to 50% at age 70
> Can increase up to Guaranteed Issue* at open enrollment if already enrolled

Spouse Coverage

> $5,000 to $250,000, not to exceed 50% of employee election
> Purchased in increments of $5,000
> Guaranteed Issue* at initial opportunity is $35,000
> Coverage amount reduces to 50% at age 70
> Can increase up to Guaranteed Issue* at open enrollment, if already enrolled

Dependent Child Coverage

> $2,000 to $10,000, not to exceed 50% of employee election
> Purchased in increments of $2,000
> All coverage amounts are Guaranteed Issue (initial or late entrants)
> One premium covers all children. Unmarried child(ren) covered to age 26.

**Guaranteed Issue is the opportunity to purchase life insurance with no medical questions asked. Guaranteed Issue is offered at your initial opportunity only. If you wish to enroll at a later date or increase your coverage above the Guaranteed Issue amount, you will need to complete Evidence of Insurability (EOI). Coverage approved through the EOI underwriting process will begin the first of the month following approval.*

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE(AD&D)

Accidental Death & Dismemberment insurance provides a lump-sum cash payment to the beneficiary if the insured's death is caused by an accident. You may purchase according to the same increments as Voluntary Life up to **10x your annual earnings or $500,000**, whichever is less. AD&D insurance is a **stand-alone benefit** and **does not** have to be combined with the purchase of life insurance. You must be enrolled in order to elect coverage for your dependents. All coverage amounts are Guaranteed Issue and do not require Evidence of Insurability.

EMPLOYEE & SPOUSE MONTHLY RATE		
EMPLOYEE AGE	**LIFE** *per $1,000*	**AD&D** *per $1,000*
<30	$0.030	Employee: $0.029 Spouse: $0.030
30—34	$0.040	
35—39	$0.070	
40—44	$0.120	
45—49	$0.170	
50—54	$0.308	
55—59	$0.467	
60—64	$0.550	
65—69	$0.990	
70+	$1.800	

CHILD MONTHLY RATE		
AMOUNTS	**LIFE**	**AD&D**
$2,000	$0.40	$0.08
$4,000	$0.80	$0.16
$6,000	$1.20	$0.24
$8,000	$1.60	$0.32
$10,000	$2.00	$0.40

Premiums will automatically calculate based on your age and salary when you enroll through THE*benefits*HUB.

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Disability

USD 261 provides eligible employees with the opportunity to purchase income protection benefits. Disability insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need. You are not eligible to receive income protection benefits if you are receiving workers' compensation benefits.

COVERAGE FEATURES	OPTION 1	OPTION 2
Benefits Begin	15th day illness/injury	31st day illness/injury
Inpatient hospital confinement due to disability	1st day	
Benefits Payable	Up to 2 Years	
Percentage of Income Replaced	Up to 66 2/3% of salary	
Purchase Increments	$100	
Minimum Benefit	$200	
Maximum Benefit	$7,500	
Rate per $100	$2.20	$1.70

For the first 90 days of disability, The Standard will pay benefits even if you have a condition subject to the pre-existing condition limitation. After 90 days, The Standard will continue benefits only for conditions for which the pre-existing condition exclusion or limitation does not apply.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is a mental or physical condition for which you or a reasonably prudent person would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications; and/or for which, as a result of any medical examination, including routine examination, was discovered or suspected in the ***90 days just prior to your effective date of coverage***. If a pre-existing condition exists then disability ***benefits are not payable in the first 12 months*** after your effective date of coverage. The Pre-existing Condition Exclusion will be applied to benefit increases greater than $300.

KPERS LONG-TERM DISABILITY INSURANCE

KPERS Long-Term Disability benefit provides income protection if you cannot work because of an illness or injury. If you become disabled, you may qualify for a disability benefit based on 60% of your annual salary. You must be disabled for 180 days and no longer receive employer compensation. The minimum monthly benefit is $100 and the maximum monthly benefit is $5,000.



TheStandard

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Accident

USD 261 offers eligible employees an opportunity to purchase Accident Insurance through The Standard. Accident Insurance can help you and your family cover unexpected out-of-pocket expenses associated with accidental injury. The plan will pay a specified amount for the covered procedure directly to you. The payment made to you is regardless of any other insurance coverage you might have, like a medical plan. If you elect coverage for yourself, you can also elect coverage for eligible family members

IMPORTANT: This is a fixed indemnity/voluntary policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

INJURIES	AMOUNT PAYABLE
Fractures	$1,500/$3,000
Dislocations	$1,200/$2,400
2nd & 3rd Degree Burns	$500 to $12,500
Concussions	$175
Cuts/Lacerations	$75 to $500
Eye Injuries	$275
MEDICAL SERVICES & TREATMENT	**AMOUNT PAYABLE**
Ambulance (Ground/Air)	$400/$1,500
Emergency Room	$200
Urgent Care	$200
Physician-Initial visit and 2nd follow up (3 days)	$200
Therapy Services (including physical therapy)	$65
Major Diagnostic Exam	$200
Medical Appliances	$100
Outpatient Surgical Facilty	$300
HOSPITAL COVERAGE (ACCIDENT)	**AMOUNT PAYABLE**
Hospital/CCU Admission	$1,250/$1,500
Hospital/CCU Confinement (Hospital up to 365 days; CCU up to 15 days)	$350/$400 per day
Inpatient Rehab (paid per accident; up to 90 days)	$150 per day
ADDITIONAL BENEFITS	**AMOUNT PAYABLE**
Accidental Death—Employee/Spouse/Child	$50,000/$25,000/$12,500
Dismemberment, Loss or Paralysis	2% to 30% of benefit
Lodging (up to 30 days per accident	$175 per day

Coverage Tier	Employee Cost
Employee	$6.78
Employee + Spouse	$11.74
Employee + Child(ren)	$18.71
Family	$22.89

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Hospital Indemnity

USD 261 offers eligible employees an opportunity to purchase Hospital Indemnity Insurance through The Standard. Hospital Indemnity Insurance pays cash benefits to employees and covered dependents in the event of a hospitalization, regardless of treatment costs or other insurance coverage. It's an affordable way for employees to keep their finances on track.

IMPORTANT: This is a fixed indemnity/voluntary policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

COVERAGE FEATURES	AMOUNT PAYABLE
Hospital Confinement (up to 31 days per confinement)	$150/day
Hospital Admission per calendar year	$500
Critical Care Unit Confinement (up to 31 days per confinement)	$150/day
Critical Care Unit Admission per calendar year	$500

Coverage Tier	Employee Cost
Employee	$10.34
Employee + Spouse	$17.41
Employee + Child(ren)	$14.89
Family	$26.35

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Critical Illness

USD 261 offers eligible employees an opportunity to purchase Critical Illness insurance through The Standard. If you are diagnosed with a critical illness or cancer, this benefit pays you a lump-sum cash benefit to help pay for treatment or bills. Employees are eligible for 100% of the benefit amounts listed below; covered dependents (children to age 26) are eligible for 50% of the employee benefit amount.

IMPORTANT: This is a fixed indemnity/voluntary policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

COVERED CONDITIONS	BENEFIT AMOUNT
Heart Attack	100%
Stroke	100%
Cancer	100%
End State Renal (kidney) Failure	100%
Major Organ Failure	100%
Coma	100%

* SEE PLAN CERTIFICATE FOR A FULL LIST

OPTION 1		
$10,000	MONTHLY PREMIUMS	
Attained Age	EE or EE & CH	EE & SP or Family
18-29	$4.20	$6.30
30-39	$6.10	$9.15
40-49	$12.00	$18.00
50-59	$24.50	$36.75
60-69	$44.90	$67.35
70+	$113.60	$170.40
OPTION 2		
$20,000	MONTHLY PREMIUMS	
Attained Age	EE or EE & CH	EE & SP or Family
18-29	$8.40	$12.60
30-39	$12.20	$18.30
40-49	$24.00	$36.00
50-59	$49.00	$73.50
60-69	$89.80	$134.70
70+	$227.20	$340.80
OPTION 3		
$30,000	MONTHLY PREMIUMS	
Attained Age	EE or EE & CH	EE & SP or Family
18-29	$12.60	$18.90
30-39	$18.30	$27.45
40-49	$36.00	$54.00
50-59	$73.50	$110.25
60-69	$134.70	$202.05
70+	$340.80	$511.20

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EMPLOYEE ASSISTANCE PROGRAM (888) 293-6948

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program (EAP) through Health Advocate that is available to you and your family in connection with your group insurance from The Standard. Its confidential information will be released only with your permission or as required by law. You, your dependents (including children up to age 26) and all household members can contact master's degree clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services. Your program includes up to three face-to-face assessment and counseling sessions per issue.



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WELLNESS BENEFIT

Haysville USD 261 will contribute $100 per fiscal year toward a health facility membership. Employees can join Clearwater Wellness Center, Derby Recreation Center, Genesis, Haysville Activity Center, Planet Fitness or the YMCA. All facilities require a recent pay stub as proof of employment. Planet Fitness Notice: Please send a copy of your contract within 30 days to Jaclyn Evans jevans@usd261.com. All others, you can show your badge/pay stub to the gym to receive your discount.

SICK LEAVE BANK

New Employees: This is your first opportunity to enroll in or decline participation in the Sick Leave Bank.Please make sure you review and enroll accordingly with your online enrollment through **THE***benefits***HUB.**

MANDATORY DIRECT DEPOSIT

Direct Deposit is mandatory. Please notify the Payroll Office if you close or change your bank account to avoid a delay in receiving your pay.

BROWN & BROWN RELIEF CENTER

Shop and save by going to https://bbinsrelief.benefithub.com/app/multiproduct. You can shop local deals, the discount marketplace as well as by category. We hope this free resource can help you find savings on everyday items that you need!

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403(B) And 457 Benefits

USD 261 offers a 403(b) Account Plan. As an eligible employee, you have the ability to participate in this plan by making voluntary salary reduction contributions on a pre-tax or Roth post-tax basis. A Plan Summary Description including a list of participating investment providers and 403(b) investment products can be found by visiting http://www.bbadmin.com/sfr_select_employer.php?id=140. This document provides an overview and outlines general provisions of the 403(b) Plan.

If you wish to begin participating in the plan, please meet with an Approved Provider to complete a Salary Reduction Agreement as instructed. This form is used to both begin participation in the plan and to change your current salary reductions. Once you have accessed the website, please follow these instructions to find a list of financial representatives that can assist you:

1. Select "Employee" from the left menu
2. Select your state from the drop-down menu
3. Select your employer from the second drop-down menu
4. Select the "Approved Providers/Products/Reps" link

You may also view other information about the plan including a copy of the plan document, forms, processing instructions and access a copy of the employee handbook. If you do not have internet access, employee handbooks are available in the Business Office.

BOARD APPROVED PARTICIPATING 403(B) INVESTMENT PROVIDERS:

American Fidelity Assurance
Ameriprise Financial Services
AXA Equitable Financial Services
Brighthouse Life Insurance
Fiduciary Trust of NH
Horace Mann Life Insurance
Metropolitan Life Insurance
National Life Group
PCS Retirement-Aspire
Reliastar / ING
Security Benefit
Voya Retirement & Annuity-Ease

BOARD APPROVED PARTICIPATING 457 PLAN PROVIDERS:

EMPOWER
Security Benefit



BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"™

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Additional Information

For More Information
If you have any questions regarding eligibility, benefit plans, enrollment periods, or would like additional information, please contact the HR Department. Need additional information? Contact the resources listed throughout this Guide to find out more about Haysville USD 261's benefits.

Contact Us with Questions

	Name	Title	Email	Phone
	**Janine McClung**	Senior Account Executive	Janine.mcclung@bbrown.com	d: (816) 843-4479 c: (816) 510-6330
	**Nancy Conard**	Senior Account Manager	Nancy.conard@bbrown.com	d: (816) 631-0750
	**Hannah Landewe**	Benefits Analyst	Hannah.landewe@bbrown.com	d. (816) 460-7258

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

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COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributi*ons* to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

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Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA 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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare

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entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage.
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18- month period of continuation coverage.
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 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.

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If you have questions

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

Keep your plan informed of address changes

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

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GRANDFATHERED HEALTH PLAN

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform
This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event.

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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) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, after you 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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.
If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE)

About Your Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare 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.

Two important things to know about your current coverage and Medicare's prescription drug coverage:

- 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.
- We have determined the prescription drug coverage offered by your provider is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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.

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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 not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.
Visit www.cms.hhs.gov/CreditableCoverage which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.
If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.
Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage 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 19 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 Plan Administrator for details.* You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage 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 or 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 800-MEDICARE (800-633-4227) (TTY: 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 800-772-1213 (TTY: 800- 325-0778).
Remember to 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).

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 plan coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them

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when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/ , which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back.

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).

MENTAL HEALTH PARITY
The Mental Health Parity and Addiction Equity Act (MHPA/ MHPAEA) of 2008 requires that group health plans must not unfairly restrict treatment with respect to coverage and cost sharing requirements for mental health or substance use disorders relative to the coverage and cost sharing requirements offered under the plan's medical and surgical benefits. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity website: www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

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

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

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 voluntary collection of information is estimated to range from fifteen (15) minutes to one (1) hour, with an average of thirty (30) minutes per response, including time for reviewing general information about requesting assistance, gathering information, completing and reviewing the collection of information, and uploading attachments if applicable. 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 Research and Analysis, 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 1210-0146. Note: Please do not return the completed request for assistance to this address.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

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ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**

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Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**

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Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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To see if any other states have added a premium assistance program since January 31, 2026, 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

PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: www.HealthCare.gov/coverage/preventive-care-benefits

SUMMARY OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

SURPRISE MEDICAL BILLS NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or 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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

<u>You are protected from balance billing for:</u>

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services

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you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

• You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
• Your health plan generally 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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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

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

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

Right to Be Free From Discrimination and Retaliation
If you are a past or present member of the uniformed service, have applied for membership in the uniformed service or are obligated to serve in the uniformed service, an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status.

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

Health Insurance Protection
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/.
If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: www.dol.gov/vets/programs/userra/poster.htm.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number above.

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