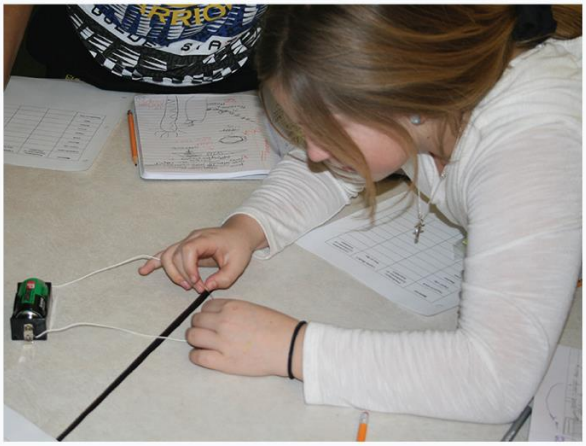

Employee Benefits Guide

2023-24

GLENDALE RIVERHILLS
SCHOOL DISTRICT

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If you have questions, please contact one of our Benefits staff members or call (414) 247-4167.

Payroll & Human Resource Specialist:
Tracy Biever, (414) 351-7170 x2105
tracy.biever@glendale.k12.wi.us

BENEFIT PROVIDER	PHONE	WEBSITE/EMAIL
HEALTH INSURANCE United Healthcare	866-633-2446	www.myuhc.com
DENTAL INSURANCE Delta Dental	800-236-3712	www.DeltaDentalWI.com
VISION INSURANCE Delta Vision	866-723-0513	www.DeltaVisionWi.com
FLEXIBLE SPENDING ACCOUNT (FSA) UHC	866-633-2446	www.myuhc.com
HEALTH REIMBURSEMENT ACCOUNT (HRA) UHC	866-633-2446	www.myuhc.com
DISABILITY INSURANCE LTD NIS	800-627-3660	https://www.nisbenefits.com/ www.NISEmployeeLogon
LIFE INSURANCE NIS	800-627-3660	https://www.nisbenefits.com/ www.NISEmployeeLogon

Benefits **Eligibility**

District personnel employed at .75 FTE or more are eligible for insurance and related benefits unless stated otherwise.

Unless otherwise noted, all costs in this summary apply to full-time employees.

Eligibility begins on the first of the month following your date of hire unless otherwise noted.

YOUR ELIGIBLE DEPENDENTS INCLUDE:

+ Your legal spouse
+ Your children, stepchildren, children of your legal spouse, or children in your guardianship up to age 26
+ Adult children, stepchildren, children of your spouse, or children in your guardianship of any age who are deemed disabled
+ Grandchild, only if the employee's dependent child (parent of grandchild) is under age 18

NEW HIRES/NEWLY ELIGIBLE

New hires or newly benefits-eligible employees are eligible for coverage starting on the first day of the month following one full calendar month of employment. If you are hired on the 1st you are eligible on the 1st.

Enrollment must be made within the first 30 days of the hire or eligibility date.

CHANGING YOUR BENEFITS OUTSIDE OF OPEN ENROLLMENT

The benefits you elect during the benefits plan year will remain in effect through the duration of the benefit plan year. By law, you can only make changes to your coverage during the year if you experience a qualifying life event, and notify Benefits within 30 days.

QUALIFYING LIFE EVENTS

A qualifying event is a personal event that may require you to either add or remove coverage for yourself and/or your dependents. These events include:

+ Marriage, divorce, or legal separation
+ Birth or adoption of a dependent child
+ Death of a dependent spouse or child
+ Gain or loss of coverage for you or your eligible dependents
+ Reaching age 26 for dependent children

IMPORTANT DEADLINE FOR QUALIFYING EVENT CHANGES

You must make any coverage change within 30 days of the qualifying event. Report this change to Tracy Biever by calling (414) 351-7175 x2105 or via email at tracy.biever@glendale.k12.wi.us, with as much information as you have, within the 30 day deadline.

You must include documentation to substantiate your qualifying event. If you miss the deadline, or do not provide the supporting documentation, changes will not be approved.

Medical Plan **with HRA**

We offer comprehensive medical coverage through United Healthcare.

Medical Benefits	United Helath Care UHC Choice Plus	
Deductible	**In-Network**	**Out-Of-Network**
Single	$2,000	$4,000
Family	$4,000	$8,000
HRA Contribution		
Single	$1,000	
Family	$2,000	
Out of Pocket Maximum		
Single	$5,350	$10,000
Family	$10,700	$20,000
Preventive Care	100%	Deductible/Coinsurance
Coinsurance	100%	80%
PCP	$30 copay	Deductible/Coinsurance
Specialist	$60 copay	Deductible/Coinsurance
Urgent Care	$100 copay, then deductible/coinsurance	Deductible/Coinsurance
Emergency Room	$350 copay, then deductible/coinsurance	
Advanced Imaging	Deductible/Coinsurance	
Tele Health/Virtual Visits	$0 copay	Deductible/Coinsurance
Pharmacy	Maximum Out of Pocket Rx Co-Pay	
Single	Included in Medical	
Family	Included in Medical	
	Advantage Drug List	
Preventive Drugs	$0	
Tier 1	$10	
Tier 2	$40	
Tier 3	$80	
Tier 4	20% Coinsurance	

The health plan works with a Health Reimbursement Account (HRA)

The HRA is administered by United Healthcare and is funded by the District. Associates in the single tier have available $1,000 and the family tier will have $2,000.

Claims are reimbursed after you satisfy the deductible and need to submitted to United Healthcare.

Medical Providers

To find an in-network provider, go to www.myuhc.com for the most up-to-date provider list.

In-Network vs **Out-of-Network**

THE BASICS

+ Knowing the difference between an in-network and out-of-network provider can save you a lot of money.
+ In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
+ Out-of-network Provider—A provider who is not contracted with your health insurance company.

GETTING THE MOST OUT OF YOUR CARE

+ Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.
+ If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

BILLING & CLAIM DIFFERENCES

+ Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

In-Network Bill

Provider	Network	Bill	Insurance	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	Appropriate discount for using an in-network provider is applied.	The bill is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and payments is sent to the patient.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-Network Bill

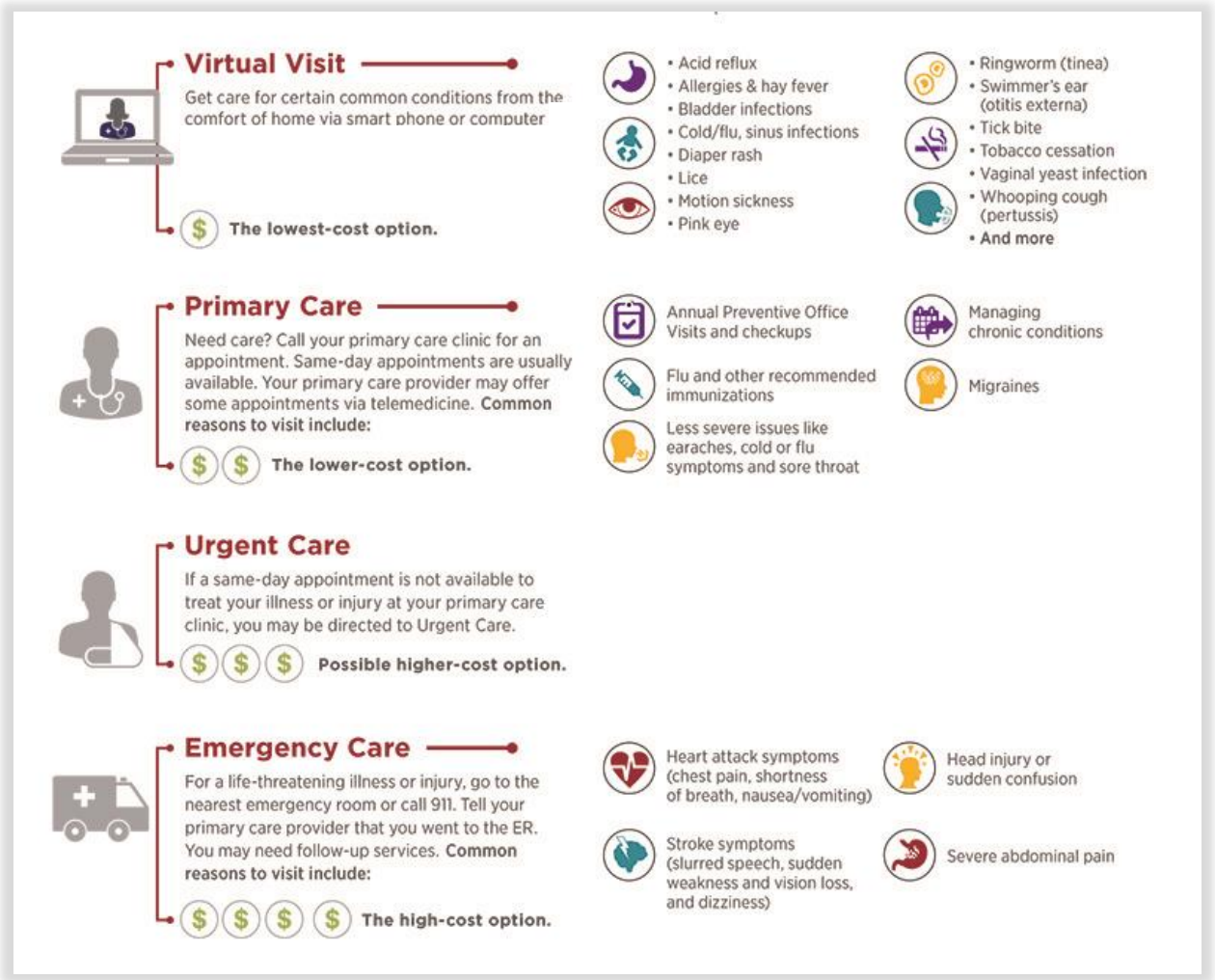
Provider	Bill	Insurance	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	The bill is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and payments is sent to the patient.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

What is **Preventive Care?**

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

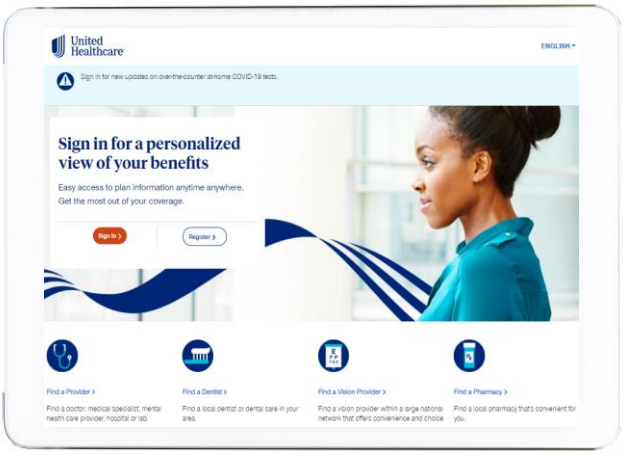
Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Need Care? **Here's Where to Go**



Access your plan easily with **myuhc.com®**

Activate your myuhc.com account after enrolling and gain access to:



+ See what's covered
+ View claim details
+ Check your plan balances
+ Find network doctors and pharmacies
+ Order prescriptions
+ Health Risk Assessment
+ Online Health Coaching
+ Personal Health Record
+ Find Care and Costs Tool (real cost of service based on your plan coverage, provider and actual contracted rates)
+ myClaims Manager – manage and pay claims online

Visit with a doctor 24/7 – **whenever, wherever**

With 24/7 Virtual Visits, you can connect to a doctor by phone or video* through myuhc.com® or the UnitedHealthcare® app.

Doctors can treat a wide range of health conditions from flu to pinkeye to migraines and more, and may even prescribe medication**

24/7 Virtual Visits can save you $130 compared to an urgent care visit and up to $2,000 compared to an ER visit.

UHC **Programs**

CANCER SUPPORT PROGRAM

Support for dealing with Cancer, This program connect you and your family to education, resources and emotional support. Access highly rated physicians and providers, a personal advocate, information to help you make informed health care decisions, social worker support and more. Call the phone number on your ID card or visit myuhc.phs.com/cancerprogram.

MATERNITY SUPPORT PROGRAM

Caring support for precious deliveries. Maternity support is designated for all parents, no matter what the pregnancy journey looks like. It includes 24/7 access to online courses covering trimester benchmarks, nutrition and exercise during pregnancy , breastfeeding and postpartum care.

QUIT FOR LIFE

Quit Tobacco for good, with a coach on your side, it may be easier to leave tobacco behind. The quit for life program includes access to a Quit Coach, a mobile app and more to help you customize a Quit plan and go tobacco free. Certificate available upon completion.

UHC REWARDS

With UHC Rewards, a variety of actions- including many things you may already be doing lead to rewards. Earn up to $300 for reaching daily goals. Download the UHC app or go to www.myuhc.com to get started.

REAL APPEAL, LOSE WEIGHT, FEEL GREAT

Connect with a community of support with Real Appeal, an online weigh loss program designed to inspire healthier behaviors. It includes group coaching sessions, 24/7 access to videos, tools to track your progress and more. Comprehensive weight loss program providing members with all of the exercise, nutrition and coaching support necessary to lose weight.

AppleFitness+ App – 12 month subscription at no cost. For more information log onto myuhc.com

ADVOCATE4ME

Customer Service Model. Representatives who are trained to resolve problems quickly the first time for Medical, Financial, Pharmacy. They can also help you find a provider and schedule an appointment.

EAP

It helps to have someone to talk to. When life gets stressful, the Employee Assistance Program (EAP) is just one phone call away. EAP coordinators are available 24/7 for confidential conversations and referrals to expert care and services. No-charge phone calls 24 hours per day - in addition, members can receive 3 free face to face visits with counselor through this program

Special Needs Program – Dedicated point of contact for families with children with special needs

Dental **Benefits**

The District offers dental benefits through Delta Dental. The district provides this benefit to eligible employees at not cost to you. Provider directories are available at www.deltadentalwi.com.

Dental Benefits	
Individual Annual Maximum	$2,000
Deductible	Single: $0; Family $0
Diagnostic & Preventive Services	100%
Basic & Major Services	80% / 50%
Orthodontic Services	
Coverage Copayment	50%
Individual Lifetime Max.	$2,000
Dependent eligible to age	26
Adult Ortho	Yes

Your Delta Dental plan includes additional benefits for those who need extra care. Evidence-Based Integrated Care is included in your plan, but you must **sign up**. The additional services allow for members additional cleanings and fluoride treatments. Members with high cardiac conditions, weakened immune systems, kidney failure or dialysis, cancer therapy, gum disease, diabetes, and pregnancy. If you fall under any of these categories click here for more information click here: **https://www.deltadentalwi.com/s/additional-benefits** .

DELTA DENTAL®

Delta Dental **Additional Programs**

EVIDENCE-BASED INTEGRATED CARE PLAN (EBICP)

Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP) provides extra benefits for individuals with certain medical conditions that have oral health implications.

Research has shown that increased frequency of cleanings and topical fluoride applications greatly impact oral health, and sometimes play a role in managing conditions such as:

+ Cancer therapy
+ Periodontal disease
+ Diabetes
+ Pregnancy
+ High-risk cardiac conditions
+ Weakened immune system
+ Kidney failure or dialysis

MOBILE APP

Delta Dental's mobile app is available for smart phones and tablets using iOS (Apple or Android. To download the app on your device, visit the App Store or Google Play and search for "Delta Dental."

+ Log in to the mobile app and select "Find a Dentist"
+ Choose your network from the dropdown menu
+ Search by address or current location

Once you've found a dentist, save your dentist to your contacts, call to schedule a visit, or get directions to their office with the touch of your finger.

Download on the App Store

Download from Google Play

AMPLIFON HEARING HEALTH CARE

1 in 9 Americans has hearing loss, and left untreated, it may profoundly impact your quality of life.

If you think you may have hearing loss, rest easy. Delta Dental of Wisconsin has partnered with Amplifon Hearing Health Care to offer you savings on hearing care and hearing aids, including:

+ **Risk-free trial** – find your right fit by trying your hearing aids for 60 days
+ **Follow-up care** – ensures a smooth transition to your new hearing aids
+ **Battery support** – battery supply or charging station to keep you powered
+ **Warranty** – 3 year coverage for loss, repairs,, or damage.

For help with hearing care or to learn more, call or visit:
www.amplifonusa.com/deltadentalwi
Phone: 1-888-901-0132

amplifon Hearing Health Care

Vision **Benefits**

The District offers dental benefits through Delta Vision of Wisconsin. Eligible employees may elect vision insurance for themselves and/or family. Provider directories are available at https://member.eyemedvisioncare.com/deltaviswi/en.

Benefit	Select Network Coverage
Routine Eye Exam – Every 12 Months	
In Network	$10 copay
Out-of-Network	Up to $35
Lenses – Every 12 Months	**In Network/Out-of-Network**
Any Lens	$10 copay
Single Vision	100% / Up to $25
Bifocal	100% / Up to $40
Trifocal	100% / Up to $55
Frames – Every 24 Months	
In Network	Up to $150, then 20% off balance
Out-of-Network	Up to $75
Contact Lenses – Every 12 Months	**In Network/Out-of-Network**
Elective	Up to $150, then 15% off balance/ Up to $120
Medically Necessary	100% / Up to $200
Note: Either eyeglass lenses or contact lenses may be reimbursed every 12 months (not both)	

DELTA DENTAL®

Flexible Spending **Account**

WHO IS ELIGIBLE:

All permanent employees working 30+ hours week.

BENEFITS YOU RECEIVE:

United Healthcare administers the Districts Flexible Spending Accounts. These accounts allow you to set aside money to pay for eligible expenses with tax-free dollars. The spending accounts offer significant tax advantages because you don't pay Social Security, Federal or State taxes on the portion of your income that you contribute to your spending account. Because you don't pay taxes on the money you contribute to your account, you gain an easy way to save money while paying for expenses you expect to incur. Qualified expenses may include child care, medical, pharmacy, over the counter medications, dental and vision expenses.

HEALTH CARE REIMBURSEMENT FSA

Use this account to cover the cost of medical, pharmacy (prescribed or over the counter), dental, vision and hearing expenses which are not paid under an insurance plan for you and your dependents. You may contribute up to $3,050 for the plan year. Employees are eligible to carryover up to $610 in unused elections while an active employee. When employment ends, the annual contribution and carryover amount can be accessed through COBRA until the end of the plan year.

Eligible healthcare FSA expenses include:

+ Deductibles, coinsurance, and copays
+ Prescription drug copays
+ Certain Over-the-counter medicines
+ Medical care items that are not prescription drugs, such as equipment (crutches), supplies (bandages and contact lens solution), and diagnostic devices (blood sugar testing kits)
+ Dental expenses, including orthodontia
+ Vision expenses, including eye exams, glasses, and contact lenses
+ Hearing expenses, including hearing aids and exams
+ Mental health expenses (does not include marriage counseling)
+ Orthopedic expenses
+ Weight loss programs (if medically necessary)
+ Medical expenses for certain procedures not covered by your plan, such as laser vision correction

Dependent Care **FSA**

DEPENDENT CARE FSA

This account is also administered by United Healthcare. Use this account to cover the cost of dependent care while you work. You may use this for expenses for the care of a child under age 13 or a disabled spouse, child or parent. If you are married, your spouse must be employed or attending classes full time for you to use the Dependent Care Spending Account. You may contribute up to $5,000 per year per household to this account or $2,500 per year if you are married and file your taxes separately.

Eligible dependent care FSA expenses include:

+ Child or adult care center that complies with State and Local regulations (not including nursing homes)
+ Sitter inside or outside the home
+ Daycare during school vacation, provided it is not primarily for educational purposes
+ Nursery school, even if the school provides educational services ·
+ Relative who cares for eligible dependents, as long as that relative is not your dependent and is age 19 or older

	FSA Healthcare		FSA Dependent Care	
	With Account	**Without Account**	**With Account**	**Without Account**
Annual Salary	$50,000	$50,000	$50,000	$50,000
Pre-tax FSA contribution	-$2,000	$0	-$5,000	$0
Taxable Income	$48,000	$50,000	$45,000	$50,000
Estimated Taxes (26% - State, Federal, FICA)	$12,480	$13,000	$11,700	$13,000
After-tax Expenses	$0	-$2,000	$0	-$5,000
Net Income	$35,520	$35,000	$33,300	$32,000
Annual Tax Savings	$520	$0	$1,300	$0

Life & AD&D and **Disability Insurance**

BASIC LIFE & AD&D INSURANCE

The District provides this benefit at no cost to its associates for basic life and AD&D coverage. Benefit amount is $10,000.

VOLUNTARY LIFE INSURANCE (POST TAX BENEFIT)

Associates who want to supplement the basic group life & AD&D insurance benefits may purchase additional coverage. After-tax premiums are paid completely by you through payroll deduction. If you do not enroll when you are first eligible, you may opt to purchase coverage at any time, but it will be subject to approval by National Insurance Services (NIS).

EMPLOYEE COVERAGE

Elections can be made in increments of $10,000, up to a maximum of $300,000 not to exceed 5x your annual salary or 7x annual salary combined Basic and Supplementary totals.

SPOUSAL COVERAGE

Increments of $5,000, to a maximum of $50,000 not to exceed 50% of the insured employee supplemental life insurance amount.

DEPENDENT CHILDREN COVERAGE

Child	Infant
Option 1 - $10,000	Option 1 - $1,000
Option 2 - $5,000	Option 2 - $500

LONG TERM DISABILITY INSURANCE

The District provides this benefit at no cost to its associates working 20 hours per week

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

	Long Term Disability
Benefits Begin	After 90 consecutive days
Benefits Payable	Until the age of 65, reduced after age 61
% of Income Replaced	90%
Maximum Benefit	$150,000 Annual $11,000 Monthly Benefit

Important **Notices**

Federal regulations require Glendale River Hills School District provide benefit eligible employees with the following important annual notices. For a complete copy of each notice contact Human Resources.

Private Health Information

A portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the protection of confidential health information. It applies to all health benefit plans. In short, the idea is to make sure that confidential health information that identifies (or could be used to identify) you is kept completely confidential. This individually identifiable health information is known as "protected health information" (PHI), and it will not be used or disclosed without your written authorization, except as described in the Plans HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws, A copy of the Plan's Notice of Privacy Practices that describes the Plan's policies, practices and your rights with respect to your PHI under HIPAA is available from your medical plan provider. For more information regarding this Notice, please contact Human Resources or the medical plan directly.

Women's Health and Cancer Rights Act

Glendale River Hills School District medical plans, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. These services include:

- 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 resulting from mastectomy (including lymphedema)

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy. For more information, contact your medical plan provider.

What about Medicare Part D

If you have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Notices are mailed to your home on an annual basis. If you would like additional information about this, please contact Human Resources.

Notice of Special Enrollment Rights

The annual open enrollment plan choices are available only once a year. The choices you make will remain in effect until the next annual open enrollment, unless you experience a qualifying event or lose eligibility under another plan. If you decline enrollment for yourself or your dependents (spouse or children) because of other medical insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan or switch to another plan option for which you are eligible if

- You or your dependents lose eligibility for that other coverage; or
- The employer stops contributing towards your or your dependents' other coverage.

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The plan will also allow a special enrollment opportunity if you or your eligible dependent(s) either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible; or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 30 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the group medical plan. This new 30-day period does not apply to any other special enrollment situations. To request Special Enrollment, or obtain more information, contact the Human Resources Department.

When Coverage Ends

We may discontinue these Benefit plans and/or all similar benefit plans at any time. Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive after coverage ends for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended. An Enrolled Dependent's coverage ends on the date your coverage ends.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2024)

PART A: General Information a

When key parts of the health care law take effect in 2014, there will be 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 and employment based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% 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.[1]

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 employee 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 your human resources representative.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer: As your employer, we offer a health plan to some employees. With respect to dependents: We do offer coverage.

3. Employer name: Glendale River Hills School District		**4. Employer Identification Number (EIN):** 39-6003456
5. Employer address: 2600 West Mill Road		**6. Employer phone number:** 414-247-4167
7. City: Glendale	**8. State:** WI	**9. ZIP code**: 53209
10. Who can we contact about employee health coverage at this job: Human Resources, 414-247-4167		
11. Phone number (if different from above):		**12. Email address:** lindsay.johnson@glendale.k12.wi.us

x If checked, this coverage meets the minimum value standard

1 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.

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 31,2021 . Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	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
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

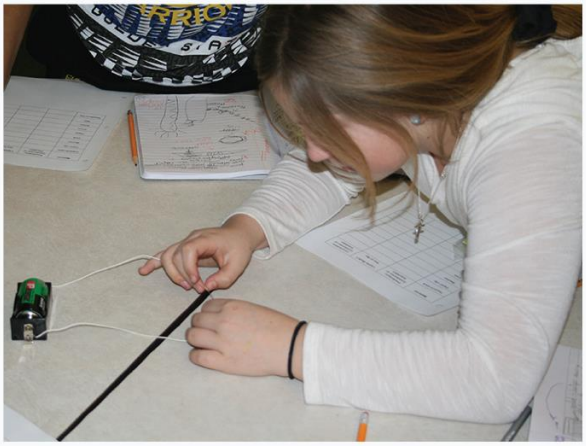
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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 1/31/2024)



GLENDALE RIVERHILLS
SCHOOL DISTRICT

ABOUT THIS GUIDE

This benefit summary provides selected highlights of Glendale River Hills School District employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The District reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.