EMPLOYEE **BENEFITS ENROLLMENT** GUIDE **2024**

Welcome to your 2024 Employee Benefits!

New Albany-Floyd County Schools recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

For any questions about the benefits outlined in the guide, please contact your Human Resources Department at hr@nafcs.org.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available but is not your Summary Plan Description (SPD). NAFCS reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

NAFCS Carriers	Website	Phone
Medical Aetna Medical	www.MyAetnaWebsite.com	1-888-290-7241
Dental Aetna Dental	www.MyAetnaWebsite.com	1-877-238-6200
Vision Aetna Vision	www.AetnaVision.com	1-877-973-3238
Basic Life and AD&D New York Life	www.newyorklife.com	1-800-225-5695
Voluntary Life and AD&D New York Life	www.newyorklife.com	1-800-225-5695
Short Term Disability New York Life	www.newyorklife.com	1-800-225-5695
Long Term Disability New York Life	www.newyorklife.com	1-800-225-5695
Voluntary Worksite *(Accident, Critical Illness, Cancer)* Guardian	www.guardiananytime.com	1-800-541-7846
Human Resources NAFCS Whitney Missi Samantha Tetrick	www.nafcs.k12.in.us/staff-post/group-benefits	 1-812-542-2123 1-812-542-2120

Eligibility

New Albany-Floyd County Schools shares in the cost by paying for a portion of the employee's health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period, unless the change is due to and consistent with a family/life status change.

Who is eligible for Benefits

- For new employees, benefits begin on the first day of the month following the date of hire or on the date of hire if requested.
- Based on your job classification, all benefits may not be available to you.

Eligible Dependents

- A spouse whom you are legally married (including same-sex spouse, if legally married)
- A dependent child up to age 26. (including biological and adopted children, stepchildren of your current marriage, including children of your same-sex spouse, and children for whom you are the legal guardian)
- Dependent children who cannot support themselves due to a physical or mental handicap that began before they reached age 26

Coverage for eligible dependents generally begins on the same day your coverage is effective. Additional carrier conditions may apply.

Benefit Change in Status

New Albany-Floyd County Schools sponsors a cafeteria plan which allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for all of those benefits with pre-tax dollars.

Participant elections made under a cafeteria plan are generally irrevocable and run from the beginning of the Plan Year (or date of initial eligibility) through the end of the Plan Year. With the exception of HSA contribution elections, you will not be able to change or revoke your elections during the Plan Year unless you experience an IRS permitted qualifying event. Any change you make must be consistent with the qualifying event. Examples of qualifying events that may entitle you to make a mid-year change in your election during a Plan Year, include:

- Birth / Adoption
- Divorce
- Death
- FMLA Related Leave
- Dependent Child Age Limit
- Marriage
- Loss of Coverage
- Eligible for Medicare

Employers do not have to permit any exceptions to the election irrevocability rule for cafeteria plans. Please consult your Plan Administrator for the specific qualifying events permitted by your plan.

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You must notify your Human Resources Department within 31 days from the Status Change in order to make a change in your benefit selections.

Enrollment Instructions

To enroll in benefits, go to: https://benefits.plansource.com/

Enter your Username and Password.

Username: Your username is the first initial of your first name, the first six letters of your last name, and the last four digits of your SSN.

For example if your name is Taylor Williams and the last four digits of your SSN are 1234, your username would be twillia1234.

Password: Your initial password is your birthdate in the following format, YYYYMMDD.

For example if your birthdate is June 4, 1979, your password would be 19790604. The first time you log in you will be promoted to change your password.

Homepage: Once you log in on the homepage, click "Get Started" to begin.

Profile: You will be asked to review and update your profile and ensure that all information listed about yourself and your family members is correct.

Shop for Benefits: You can now begin shopping for benefits! Educational material about the specific plan type is available at the top of the page.

Select Plan: To select a plan, indicate which family members are covered by clicking "edit family covered" and select each family member you'd like to be on the plan.

Click "Update Cart" to choose a plan.

Shopping Cart: The shopping cart displays a running total of your combined benefits costs and shows your progress. **You will need to select or decline a plan in each benefit type before you can check out.**

Checkout: To finalize your choices, click "Review and Checkout." You must complete the checkout process in order to be enrolled in benefits.

Medical Insurance

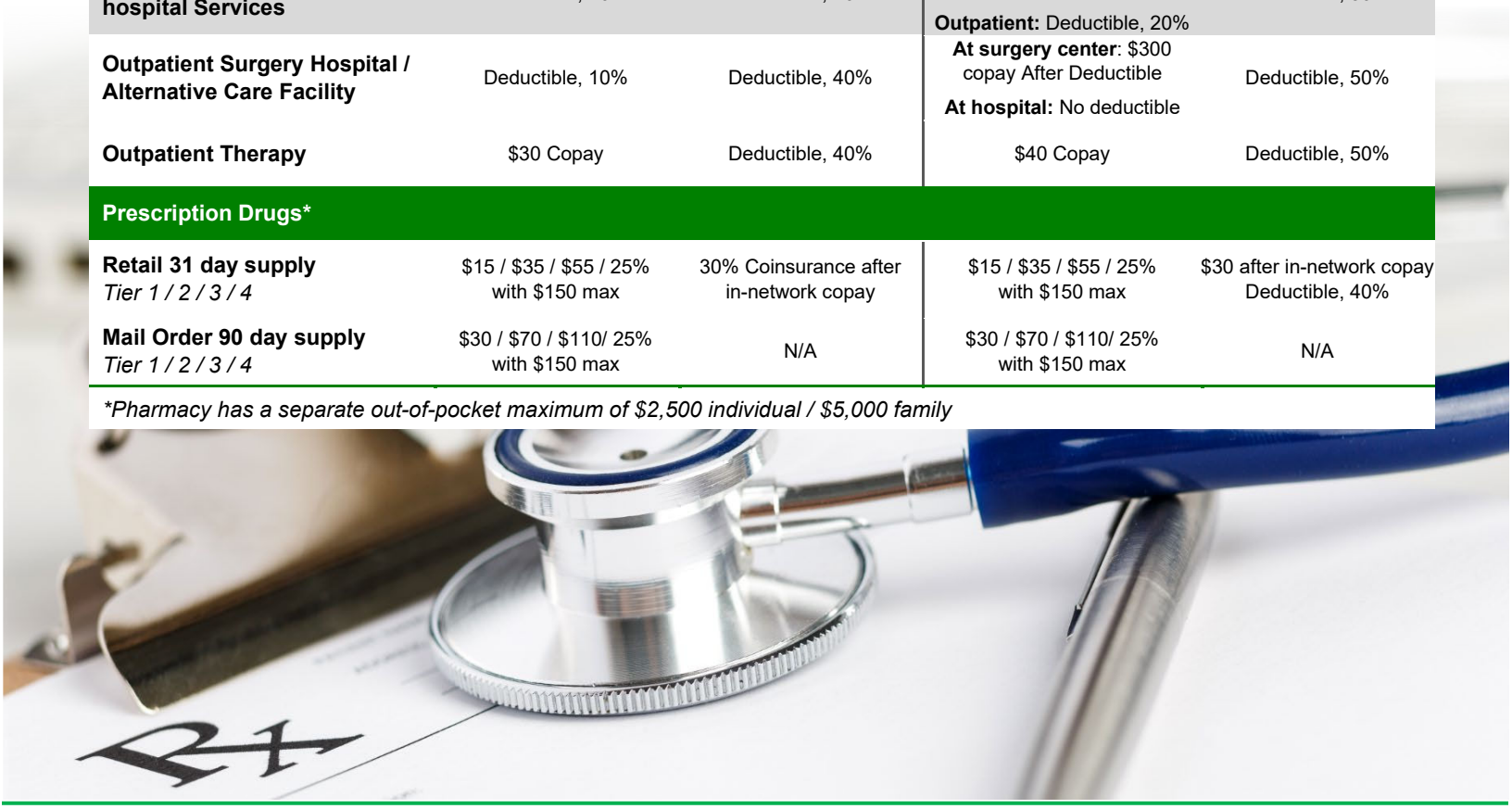
Effective 1/1/2024 there is a carrier change from Humana to Aetna.

Aetna medical plans offer freedom of choice with access to a large national network of physicians, hospitals and health care professionals (clinics, labs, care centers, etc.). You have a choice of four medical plans. To find a network provider, visit www.MyAetnaWebsite.com or call 1.888.290.7241.

Get the most out of your Aetna benefit plan, register online and take advantage of the easy-to-use tools and resources available to members.

	PPO $500 Managed Choice Open Access		PPO $1,250 Managed Choice Open Access	
	In Network	Out of Network	In Network	Out of Network
Deductible *(Individual / Family)*	$500 / $1,000	$1,500 / $3,000	$1,250 / $2,500	$3,750 / $7,500
Out of Pocket Maximum *(Individual / Family)*	$2,500 / $5,000	$7,500 / $15,000	$4,500 / $9,000	$13,500 / $27,000
Physician Office Visits *Primary Care / Specialist*	$20 Copay $40 Copay	Deductible, 40%	$30 Copay $50 Copay	Deductible, 50%
Preventive Care	Covered In Full	Deductible, 40%	Covered In Full	Deductible, 50%
Emergency Room Copay	$200 Copay *(waived if admitted)*	$200 Copay *(waived if admitted)*	$200 Copay *(waived if admitted)*	$200 Copay *(waived if admitted)*
Urgent Care Copay	$75 Copay	Deductible, 40%	$75 Copay	Deductible, 50%
Inpatient & Outpatient hospital Services	Deductible, 10%	Deductible, 40%	**Inpatient:** $200 Copay per Day for First 3 Days **Outpatient:** Deductible, 20%	Deductible, 50%
Outpatient Surgery Hospital / Alternative Care Facility	Deductible, 10%	Deductible, 40%	**At surgery center**: $300 copay After Deductible **At hospital:** No deductible	Deductible, 50%
Outpatient Therapy	$30 Copay	Deductible, 40%	$40 Copay	Deductible, 50%
Prescription Drugs*				
Retail 31 day supply *Tier 1 / 2 / 3 / 4*	$15 / $35 / $55 / 25% with $150 max	30% Coinsurance after in-network copay	$15 / $35 / $55 / 25% with $150 max	$30 after in-network copay Deductible, 40%
Mail Order 90 day supply *Tier 1 / 2 / 3 / 4*	$30 / $70 / $110/ 25% with $150 max	N/A	$30 / $70 / $110/ 25% with $150 max	N/A

**Pharmacy has a separate out-of-pocket maximum of $2,500 individual / $5,000 family*



Medical Insurance *continued.*

	HDHP $3,200		HDHP $5,000	
	In Network	Out of Network	In Network	Out of Network
Deductible *(Individual / Family)*	$3,200 / $6,400	$6,000 / $12,000	$5,000 / $10,000	$15,000 / $30,000
Out of Pocket Maximum *(Individual / Family)*	$3,200 / $6,400	$12,000 / $24,000	$5,000 / $10,000	$17,500 / $35,000
Physician Office Visits *Primary Care / Specialist*	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Preventive Care	Covered in Full	Deductible, 30%	Covered in Full	Deductible, 30%
Emergency Room Copay	After Deductible, Covered in full	After In-Network Deductible, Covered in full	After Deductible, Covered in full	After In-Network Deductible, Covered in full
Urgent Care Copay	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Inpatient & Outpatient Professional Services	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Outpatient Surgery Hospital / Alternative Care Facility	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Outpatient Therapy	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Prescription Drugs				
Retail 31 day supply *Tier 1 / 2 / 3 / 4*	After Deductible, Covered in full	Deductible, 30%	After Deductible, Covered in full	Deductible, 30%
Mail Order 90 day supply *Tier 1 / 2 / 3 / 4*	After Deductible, Covered in full	N/A	After Deductible, Covered in full	N/A

Aetna Value Added Benefits

As part of your Aetna medical coverage, you also have access to a number of value added benefits offered through Aetna.

Aetna

When you enroll in a Aetna medical plan, you have access to the Aetna health Secure member website at MyAetnaWebsite.com. Here you'll find a number of tools at your fingertips to help you make the most of your plan, manage your medical costs and stay on top of your health.

Getting started on the site is easy. Go to MyAetnaWebsite.com, click "Register" on the left side and follow the instructions. Once you're in, you can view and print claims and a summary of your plan benefits, explore symptoms, treatments and tests, create and view your personal health record, take a health assessment, order new ID cards, and use planning tools to track your spending and estimate costs

Aetna Provider Finder

Aetna Provider Finder is Aetna's online provider look-up tool. To find a participating provider, visit MyAetnaWebsite.com and click on "Search" under Find a doctor or pharmacy. You can search using your Member ID or use your coverage type and zip code. You will need to enter **Managed Choice Open Access** as the network. This service is also available on Aetna and on the Aetna app for your smart phone. If you need more assistance finding a network provider, call the Customer Service number on the back of your Aetna medical plan ID card.

Teladoc

If you need immediate non-emergency medical care but can't get in to see your primary doctor, you can consult a doctor 24/7 with Aetna's partnership with Teladoc. You will be connected with U.S. board-certified doctors who can help resolve many of your medical issues over the phone or through video consults. Doctors can diagnose a condition, recommend treatment and send a prescription directly to your pharmacy. Telemedicine is ideal when you need to see a doctor for minor illnesses such as colds, sore throats, flu symptoms, allergies, sinus infections, ear or eye problems or skin conditions. It's an easy and inexpensive alternative to an office visit – and no appointment is needed. Set up your account or log in today. Visit Teladoc.com/Aetna or Call 1-855-TELADOC (835-2362).

WELLNESS TOOLS FOR YOU

Wellness Portal: Login at aetna.com. Click on "Health & Wellness" to access healthy recipes, courses mindfulness activities and other resources. $50 gift card for completing the health assessment and participating in an online coaching program.

Aetna One Choice Care Management: Group coaching, online health coaching and one-on-one personalized nurse support for acute care and chronic condition management. Log in at aetna.com for more information.

Nurseline: A 24-hour nurseline for your whole family to get health information and possibly prevent an unneeded trip to the emergency room. Aetna.com or 800-556-1555

Discount Programs: Log in at aetna.com and click on Health & Wellness to find savings on eyewear, hearing solutions, weight loss programs, gyms, and health food products

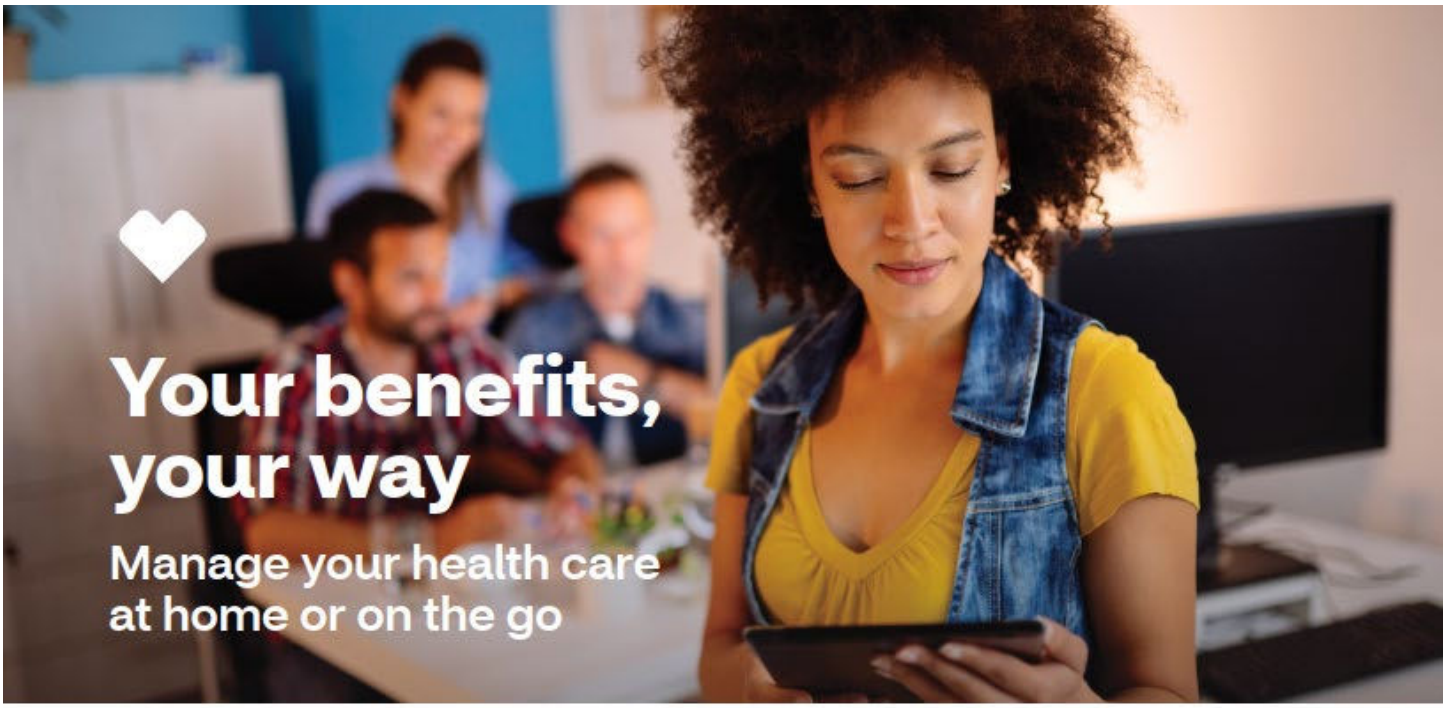
Mental Health: AbleTo Behavioral Care Program provides virtual, personalized support to manage emotions and improve overall health. Ableto.com/Aetna or 844-330-3648

Maternity Program: Learn about what to expect before and after delivery, early labor symptoms, newborn care and more. Log in at aetna.com and click on Health & Wellness or call 1-800-272-3531.

Teladoc Health: This is a low cost, convenient and quality alternative to emergency room (ER) and urgent care for non-emergency medical care. Care is available 24/7 by web, phone and the Teladoc mobile app. Teladoc also offers mental health, dermatology and caregiver services. Visit Teladoc.com/Aetna: Call 1-855-TELADOC (835-2362) or download the app.

* Only available when enrolled in an Aetna Medical Plan.

AssuredPartners



Stay on top of your benefits

- Review your benefits and what's covered.
- Track your spending.
- View and pay claims on your member website.
- See your ID card online.
- Get cost info before you get care.*

Connect to care

- Find in-network providers, including virtual care.
- Locate walk-in clinics and urgent care centers near you.
- See reviews of providers.

Get started today

Visit **MyAetnaWebsite.com** to register for your member website.

Get the **Aetna Health℠ app** by texting **"AETNA"** to **90156** to receive a download link. Message and data rates may apply.**

— OR —

Scan the QR code to download the **Aetna Health℠ app**.

*Estimated costs are not available in all markets or for all services. We provide an estimate for the amount you would owe for a particular service based on your plan at that very point in time. It is not a guarantee. Actual costs may differ from an estimate for various reasons including claims processing times for other services, providers joining or leaving our network or changes to your plan. Health maintenance organization (HMO) members can only get estimated costs for doctor and outpatient facility services.

Terms and Conditions: **Aet.na/Terms. Privacy Policy: **Aetna.com/legal-notices/privacy.html**. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna® with a link to download the Aetna Health℠ app. Consent is not required to download the app. You can also download by going to the Apple® App Store® or Google Play.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Apple® is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Google Play is a trademark of Google LLC.

Aetna.com

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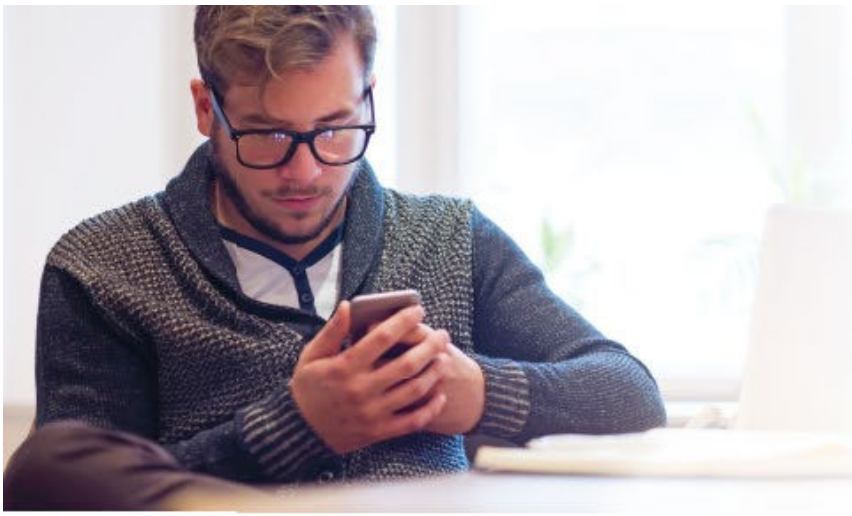


You've got Teladoc Health

made available through aetna | Teladoc HEALTH

Access to quality care at your fingertips

General Medical
$56 or less/visit

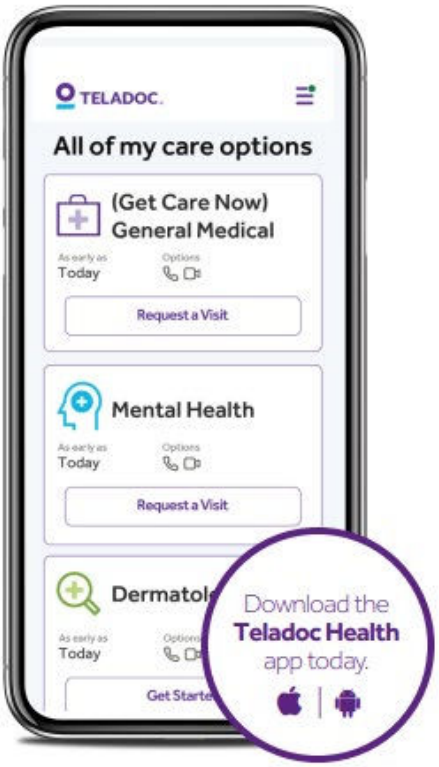
Talk to a licensed doctor for non-emergency conditions 24/7
Flu • Sinus infections • Sore throats • And more

Mental Health
$90 or less/ therapist visit
$215 or less/ psychiatrist first visit
$100 or less/ psychiatrist ongoing visit

Talk to a therapist 7 days a week (7 a.m. to 9 p.m. local time)

Dermatology
$85 or less / consult

Upload images of a skin issue online and get a custom treatment plan within two days
Eczema • Acne • Rashes • And more



Set up your account or log in today

Visit Teladoc.com/Aetna

Call 1-855-TELADOC (835-2362) | Download the app

Less than an urgent care/ER visit, your cost is never more than a doctor visit!

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Group ID: 155218

24-Hour Nurse Line

A 24-hour information line for your health questions

Talk to a registered nurse anytime

With the 24-Hour Nurse Line, you can speak to a registered nurse about health issues — whenever you need to.*

Plus:

- It's toll-free.
- You can call as many times as you need — at no extra cost.
- Your covered family members can use it, too.

You could save time, money and a trip to the ER

The 24-Hour Nurse Line can provide helpful information and possibly prevent an unneeded trip to the emergency room (ER). That can be a money-saver.

Plus, you'll be able to make smarter health decisions. You'll have reliable information you can trust — and it's only a phone call or click away.

*While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

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AetnaStudentHealth.com

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More reasons to use the 24-Hour Nurse Line

You can:

- Get information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive emails with links to videos that relate to your question or topic

Your online source for health information

Prefer to go online for health information? Check out the 24-Hour Nurse Line page on your member website.

Here's what you can do:

- Send us an email.
- Use our symptom checker.
- Learn about treatment options and health risks.
- Research medications.

It explains things in terms that are easy to understand.

Get the information you need

We asked our members what they liked about the 24-Hour Nurse Line.[1] Here's what they said:

- 93 percent said it has improved their satisfaction with the plan.
- 95 percent said this program was an important part of their health plan benefits.

Two ways to get health information fast

1. Call a registered nurse anytime, toll-free.
2. Visit your member website at **AetnaStudentHealth.com**.

Get health information — when and where you need it.
Call **1-800-556-1555 (TTY: 711)**.*
Or log in at
AetnaStudentHealth.com.

THIS IS NOT INSURANCE. THIS IS A PROGRAM AVAILABLE WITH THE MEDICAL PLAN.

*Ask the relay operator to dial **1-800-556-1555** and select the option to speak to a nurse.

[1]24-Hour Nurse Line (formerly known as the Informed Health® Line) Member Satisfaction Survey. 2018.

Student health insurance plans are insured by Aetna Life Insurance Company (Aetna). In MD and NJ, student medical insurance is insured by Aetna Health and Life Insurance Company (AHLIC). Self-insured plans are funded by the applicable school and administered by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company, Aetna Health and Life Insurance Company and their affiliates.

This material is for information only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health benefits and health insurance plans contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna Student Health plans, refer to **AetnaStudentHealth.com**.

Policy forms issued in Missouri include: AL SH HPol-H 02.

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AetnaStudentHealth.com

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Health Savings Accounts

Effective 7/1/2023 NAFCS has partnered with Everwise and UMB as the HSA providers.

What is a High Deductible Health Plan

A HDHP is a plan with a certain annual deductible amount and a maximum out-of-pocket limit.

Sometimes referred to as consumer-driven health insurance, a HDHP still covers you for catastrophic illness and injury—what health insurance was originally intended to do.

Office visits and prescription drugs are subject to the deductible. This means you pay a Aetna negotiated discount price instead of a fixed co-pay until you reach your deductible.

What is a Health Savings Account (HSA) and how does it work?

A Health Savings Account is a tax-advantaged trust account that allows you to take charge of your health, your savings and your future.

It allows you to put away tax-free dollars to help pay for your eligible healthcare expenses including medical, prescription drugs, dental, vision, certain premium expenses like COBRA and Medicare premiums, etc., both today and in the future.

The 2024 maximum annual contribution to an HSA is $4,150 for single coverage and $8,300 for family coverage (combined between yourself and “the company”). The IRS determines the contribution maximums annually. If you are age 55 or older, you can contribute an additional $1,000.

Advantages of an HSA

- Money you put into your account is deducted pretax therefore reducing your taxable income.
- Money that stays in your account earns tax-free interest.
- Money you pay from your account to pay for your qualified healthcare expenses is not taxed.
- Money rolls over from year-to-year – no “use it or lose it” restriction.

Who is eligible for an HSA?

- You must be enrolled in a qualified High Deductible Health Plan (HDHP).
- You cannot be covered by any other health plan that is not a qualified HDHP (certain exceptions). Disqualifying health plans include general-purpose health FSAs and HRAs provided by your employer or your spouse’s employer.
- You cannot be enrolled in Medicare or receiving Social Security.
- You cannot be claimed on another person’s tax return.
- You have not received VA medical benefits at any time over the past three months.

Basic Benefits of the High Deductible Health Plan

- Visits to any doctor or facility for covered service, just as usual.
- Your plan includes deductibles, coinsurance and a limit on what you pay out-of-pocket.
- Annual routine preventive care services are included in your plan. You generally do not pay for these services; not even an office visit co-pay.
- Certain Preventive Prescriptions are also included. On these the deductible is waived and you only pay the coinsurance.

When do I use my HSA?

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 and coinsurance) billed by the physician, facility, or pharmacy, or you can choose to save your HSA dollars for a future medical expense. In addition, HSA dollars are available to pay for dental, vision and other expenses as well.

How does the HDHP Deductible Work?

Under the HDHP, your annual deductible and out-of-pocket maximum includes both medical and pharmacy expenses. All expenses are your responsibility until the deductible is reached (except qualified preventive care). For family coverage, expenses are your responsibility until the entire family deductible is satisfied. One or more persons may satisfy the family deductible.

Health Savings Accounts *continued*

How are benefits covered after the deductible is satisfied?

Once you have satisfied the in-network deductible, remaining qualified expenses are covered by the HDHP plan at 100 percent up to the out-of-pocket maximum.

How does the HDHP work if I go out-of-network?

Out-of-network coverage is covered. You must satisfy the out-of-network deductible then expenses are covered at the out-of-network coinsurance level.

Can ineligible expenses be reimbursed from an HSA?

Ineligible disbursements from an HSA are subject to a 20 percent penalty. Neither the trustee, bank, insurance company nor NAFCS are required to determine if a claim submitted for reimbursement is a qualifying medical expense.

The employee is responsible to include the amount withdrawn from an HSA for a non-qualifying medical expense is added to the account beneficiary's income and subject to a 20 percent penalty. Where funds are distributed as a result of the account beneficiary's death, disability, or after he or she is eligible for Medicare, the 20 percent penalty does not apply.

Why should I elect an HSA?

- Tax Benefits
  - ✓ HSA contributions are excluded from federal income tax
  - ✓ Interest earnings are tax-deferred
  - ✓ Withdrawals for eligible expenses are exempt from federal income tax

- Unused money is held in an interest-bearing savings or investment account
- Lower employee contribution
- Company contribution

Long-Term Financial Benefits

- Save for future medical expenses
- Funds roll over year to year
- This is your account, you take it with you if your employment ends.

Choice

- You control and manage your healthcare expenses.
- You choose when to use your HSA dollars to pay for your healthcare expenses.
- You choose when to save your HSA dollars and pay healthcare expenses out of pocket.

Who will administer the HSA?

Everwise and UMB administers the HSA bank accounts for NAFCS employees that are enrolled in the qualified High Deductible Health Plan.

Employees with an existing First Financial HSA account may be grandfathered.

Flexible Spending Accounts

What is a flexible spending account?
A flexible spending account (FSA) is an account in an employee's name that reimburses the employee for qualified health care or dependent care expenses. It allows an employee to fund qualified expenses with pre-tax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement up to the total value of the account for covered expenses incurred during the benefit plan year and any applicable grace period.

"Use-it-or-lose-it" Rule
As required by the Internal Revenue Service (IRS), an FSA has a "use-it-or-lose-it" provision stating that any unused funds at the end of the plan year (plus any applicable grace period) will be forfeited. When electing an FSA during open enrollment, the employee must specify how much he or she would like to contribute to the FSA for the year. The goal is to choose an amount that will cover medical or dependent care expenses, but that is not so high that the money will be forfeited at the end of the year.

In addition, employers may allow participants to carry over up to $500 in unused funds into the next year. Similar to the grace period rule, this carry-over rule is strictly optional, and employers must choose to implement it. The carry-over provision is only available if the plan does not also incorporate the grace period rule.

Types of FSAs
There are two different types of FSAs: health care accounts and dependent care accounts. An employee can elect to have both types of accounts and contribute separate pre-tax dollars to each. These accounts are kept separate; for instance, an employee could not be reimbursed for dependent care expenses from his or her health care account.

Health Care Accounts
A health care FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. A health care FSA offered through a cafeteria plan must limit the amount of salary reduction contributions that employees can make.

The Affordable Care Act (ACA) revised the definition of "qualified medical expenses" for purposes of reimbursement from health care FSAs. Under the revised definition, qualified medical expenses include amounts paid for medicines or drugs only if the medicines or drugs are prescribed (determined without regard to whether the drugs are available without a prescription) or if they are insulin. This means that health care FSAs may not reimburse the cost of over-the-counter medications that do not have a prescription.

Examples of qualified medical expenses include deductibles and copayments for an individual's health plan. Eye exams, eyeglasses, contact lenses, hearing exams, hearing aids, physical exams and smoking cessation programs are also covered. For a complete list of qualified medical expenses, visit the IRS website.

Dependent Care Accounts
The second type of FSA is a dependent care account. This account can be used to pay for care of dependent children under the age of 13 by a babysitter, day care center, or before- or after-school program. Care for a disabled spouse, parent or child over the age of 12 is also eligible for reimbursement.

Many of the same general rules that apply to health care FSAs also apply to dependent care accounts, such as the "use it or lose it" rule. However, there are some other important differences between the two types of accounts. For dependent care accounts:

- There is an annual limit as to how much an employee can contribute.
- The money in a dependent care account is not available until it has been deposited by the employee; and
- Dependent care expenses cannot be reimbursed until they are actually incurred. This can be an issue when child care centers "pre-bill" for services, and employees are required to pay in advance.

Contribution Limits

The 2023 maximum yearly contribution limits are as follows:

Healthcare FSA	$3,050
Dependent Care FSA	$5,000
Limited Healthcare FSA	$3,050

The 2024 contribution limits have not yet been released. If the limit is increased for 2024 employees will be notified via email communication.

Dental Insurance

Effective 1/1/2024 there is a carrier change from Delta Dental to Aetna

With Aetna you have freedom of choice when selecting a dentist. To find a participating dentist in the Aetna network, visit www.MyAetnaWebsite.com or call 1.877.238.6200.

The dentist you select will determine the cost savings you receive when seeking care. You may choose any dentist, even if they do not participate in Aetna network.

Non-participating dentists are not contracted to accept Aetna negotiated fees as payment in full. If you choose a non-participating dentist, you will be responsible for any charges above Aetna's negotiated fee. You may also be required to pay in full at the time of service and submit a claim form to Aetna for reimbursement. Then the benefit payment will be mailed to you directly.

	PPO II Extend Network	Out of Network
Deductible	$25 Single / $75 Family	
Maximum Benefit	$1,000	
Class I Benefits *(Routine exams, cleanings, X-rays, sealants and fluoride)*	Covered in Full, deductible waived	Covered in Full, deductible waived
Class II Benefits *(Routine fillings, crowns, Endodontics, Periodontic, Relines and Repairs)*	50%, subject to deductible	50%, subject to deductible
Class III *(dentures, bridges)*	50%, subject to deductible	50%, subject to deductible
Orthodontic Services *(dependent children to the end of the month in which they turn 19)*	50%	50%
Orthodontia Lifetime Maximum	$1,000	

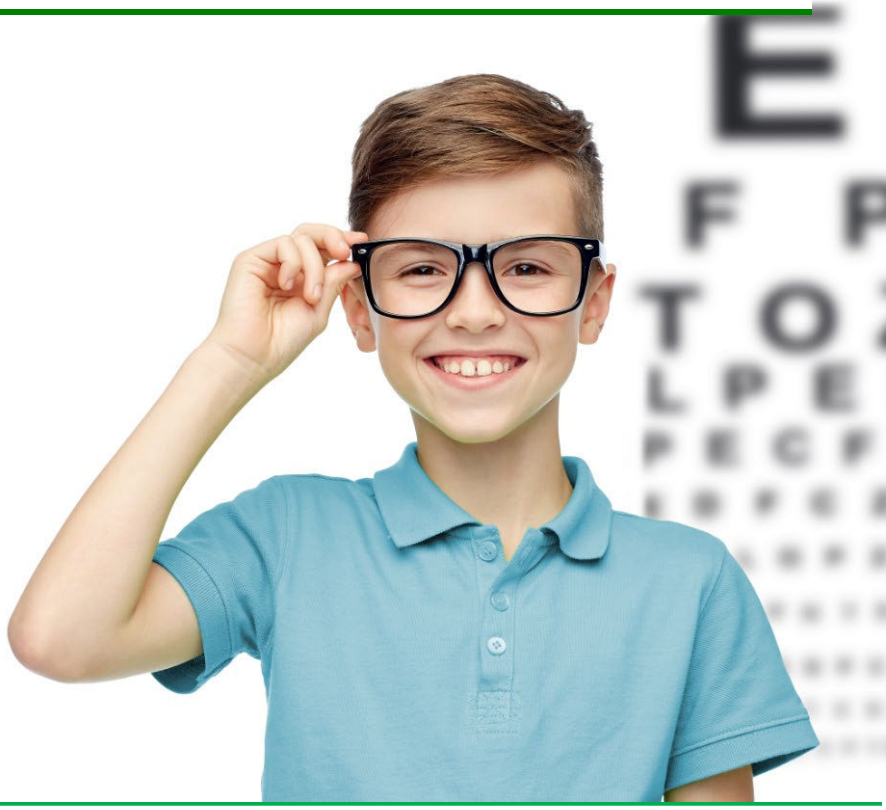
To locate a participating provider visit www.MyAetnaWebsite.com or call 1.877.238.6200

Vision Insurance

Effective 1/1/2024 there is a carrier change from Humana to Aetna.

New Albany-Floyd County Schools provides employees with vision coverage through Aetna. The Aetna Vision Plan provides rich, flexible vision plans covering exams and materials, making it more affordable to keep your eyes healthy. For more information or to locate a participating provider please visit www.AetnaVision.com or call 1.877.973.3238.

	Network	Out of Network
Routine eye exam *(every 12 months)*	$10 copay	$30 allowance
Diabetic Eye Care *(Exam, retinal imaging - up to 2 per year)*	$0 Copay	
Eyeglass Frames *(every 24 months)*	$130 frame allowance, then 20% off remaining balance	$65 allowance
Standard Plastic Lenses Single Bifocal Trifocal	$15 Copay	$25 allowance $40 allowance $60 allowance
Lens Enhancements Standard Polycarbonate (under age 19) UV Coating Tint	$0 Copay $15 Copay $15 Copay	No allowance on lens enhancements when obtained out-of-network
Contact Lenses *(every 12 months)*	In lieu of eye glasses	
Elective Conventional	$130 allowance, 15% off remaining balance	$104 allowance
Elective Disposable	$130 allowance (no additional discount)	$104 allowance
Medically Necessary	Covered in Full	$200 allowance



Basic Life and AD&D Insurance

Basic Life and AD&D insurance provides a benefit in the event that you die or are injured in an accident. The AD&D portion of the insurance pays all or a portion of the full benefit based on the loss you suffer.

Long-Term Disability Insurance

LTD insurance is designed to help you replace a portion of your monthly income if you are unable to work for an extended period of time due to illness or injury. The plan replaces a percentage of your salary, up to a maximum amount per month after you have been disabled for 120 days.

Voluntary Life and AD&D Insurance

In addition to the provided life insurance, you may also purchase additional life insurance coverage through New York Life for yourself, your spouse and your dependent children. Note: Guarantee issue only applies at time of initial eligibility.

Voluntary Life and AD&D	
Employee Benefit	Maximum of $500,000 Guarantee Issue: $150,000
Spouse Benefit	Maximum of $500,000 not to exceed 100% of the employee's amount Guarantee Issue: $25,000
Child Benefit	From 6 months to 26 years old $10,000 From birth to 6 months - $1,000

Short-Term Disability Insurance

Short-term disability insurance pays a portion of your earnings if you cannot work due to a non-work-related illness or injury. You must meet the definition of disability for benefits to be payable. At enrollment, you can choose various amounts of disability coverage. The maximum benefit cannot exceed 60% of your weekly earnings, and your premium is based on your current age and the amount of coverage you are eligible to buy.

Note: *This plan has a 6/12 pre-existing limitation which means that the plan will not pay for a disability within the first 12 months after your effective date if you were treated for the condition in the 6 months prior to enrollment in the plan.*

Important Notice

During this enrollment period, New York Life will allow you to enroll into the Voluntary Term Life and AD&D option up to a Guaranteed Issue amount of $150,000. You will not be required to provide proof of good health to take advantage of this offer.

In addition, New York Life will allow you to enroll into the Short-Term Disability (STD) option without providing proof of good health during this enrollment period. The Pre-Existing limitation will still be applicable.

New York Life Value Added Benefits

Available with your New York Life insurance plans, the following programs can offer peace of mind – and savings – during a difficult time. These benefits are offered at no cost to you.

Life Assistance Program (LAP)

New York Life's Life Assistance Program is available to help you and your family when you are faced with a challenge. The LAP works as a voluntary counseling program and offers information and support for many questions and issues you face in your day-to-day life. Some of the services available through the LAP include:

- 24-hour crisis intervention and phone consultations with behavioral health specialists
- Consultations and referrals for work-related issues
- An online resource library with a variety of health and emotional well-being content
- New York Life's Health Rewards program

Will Preparation

New York Life provides you with access to a secure online website that allows you to create a customized will or other legal documents, such as a living will or power of attorney.

For more information, visit www.NewYorkLife.com or call 1-800-225-5695.

New York Life Secure Travel

If you experience an emergency while traveling, you can call New York Life Secure Travel®. Representatives are available 24 hours a day, 365 days a year whenever you travel more than 100 miles from home. Services include: pre-trip planning, travel assistance, and emergency assistance.

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Voluntary Benefits

As a supplement to the benefits you already receive, NAFCS offers the following voluntary benefits through Guardian: Group Accident Insurance, Hospital Indemnity Insurance, Critical Care Illness and Cancer Insurance. You pay premiums for these coverages through payroll deductions. For additional information about these benefits, visit www.guardianantytime.com or call 1.800.541.7846.

Group Accident Insurance

When an accident or injury happens, having a financial safety net in place to help cover unexpected costs like emergency care and rehab can be a lifesaver. Benefit amounts are preset and are not based on the medical expenses you are charged. You receive a lump sum payment specific to the injury or treatment you require.

Hospital Indemnity Insurance

Needing hospitalization due to sickness or injury can happen to anyone. While your medical insurance may help cover hospital bills in these situations, it may not coverall of the costs associated with a hospital stay, such as deductibles and co-pays, transportation, and lodging.

Critical Illness Insurance

If you have a heart attack or stroke, or get diagnosed with a covere3d serious illness or condition, you should no have to worry about how you are going to pay for unexpected costs that may come your way. Things like provider out of pocket costs, potential loss of income, childcare, and travel expenses can add up quickly. Critical Illness pays a lump sum cash benefit directly to you, which helps you manage those unexpected costs.

Cancer Insurance

In the unfortunate event you are diagnosed with cancer, having insurance protection in place can help with the cost of your treatment and other medical expenses not covered by your medical plan. Benefits are paid directly to you, regardless of any other insurance you have.

Retirement Benefits

NAFCS offers a 403(b) Retirement Plan to help you save for retirement. You can contribute pre-tax dollars up to the current IRS annual maximum of $22,500. If you are age 50 or older, you can make an additional catch-up contribution of $7,500.

The 2024 contribution limits have not yet been released. If the limit is increased for 2024 employees will be notified via email communication.

You can choose from a variety of investment options that meet your personal investment goals. Call an Edward Jones Financial Agent to get started.

Kevin Boehnlein 1401 Veterans Parkway, Suite 400 Clarksville, IN 47130 812.284.4963 (FCHS, Georgetown, ASC, ESC, FSC)	**Todd Klinglesmith** 3833 Charlestown Road New Albany, IN 47150 812.949.0667 (Grant Line, Prosser, Scribner)
Bill Kaiser 146 East Elm Street New Albany, IN 47150 812.944.5100 (NAHS, Hazelwood, Slate Run)	**Robert Ritz** 2441 State Street, Suite B New Albany, IN 47150 812.949.2198 (Green Valley, Mt. Tabor, Transportation)
Brad Rumple 710 Highlander Point Drive Floyd Knobs, IN 47119 912.923.6596 (FKE, Greenville, Highland Hills)	**Greg Nash** 133 East Sporting Street New Albany, IN 47150 812.944.8312 (CANA, Fairmont, SEJ)

Enrollment Steps

New Hires:

1. New hires will contact one of the agents listed above and complete the enrollment application.
2. Complete a Salary Reduction Agreement to open your account.
3. Submit the Salary Reduction form to HR at the Central Administration Office.

Current Employees:

1. Complete a Salary Reduction Agreement to open your account.
2. Submit the Salary Reduction form to HR at the Central Administration Office.

Employees are allowed to make four (4) changes any time during the year.

With questions, contact:
Samantha Tetrick
Human Resources and Benefits Generalist
812.542.2120
stetrick@nafcs.org

Compliance Notices

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 1, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 1, 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.

Continuation of Coverage under COBRA

Employers who employ 20 or more employees are subject to the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end because of certain "qualifying events", such as termination of employment for reasons other than gross misconduct, reduction in hours, divorce, legal separation, death, or a child ceasing to meet the definition of dependent under the group health plan coverage. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if group health plan coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

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.

For more information about your rights and obligations under COBRA, you should review the Plan’s Summary Plan Description or contact Humana at 1-800-448-6262

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent, because 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or the Children’s Health Insurance Program (CHIP), or when you and/or your dependents gain eligibility for state premium assistance. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

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

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 1-800-448-6262.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Providers Choice

Name of group health plan or health insurance issuer generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from name of group health plan or issuer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

USERRA Health Insurance Protection

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

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.

For more information about your rights to continue your coverage, contact the plan administrator.

Voluntary Wellness Program

Your wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If an HRA is part of the program include – "If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease)".] [If a biometric screening is part of the program include – "You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested". You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of indicate the incentive for specify criteria. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to indicate the additional incentives may be available for employees who participate in certain health-related activities if any or achieve certain health outcomes specify particular health outcomes to be achieved, if any. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as services that may be offered. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and ABC Company may use aggregate information it collects to design a program based on identified health risks in the workplace, will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Specify any other or additional confidentiality protections if applicable. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your plan administrator.

Wellness Plan Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you, considering your health status.

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

Important Notice from New Albany Floyd County Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage New Albany Floyd County Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **New Albany Floyd County Schools has determined that the prescription drug coverage offered by the New Albany Floyd County Schools Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits.
If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the New Albany Floyd County Schools benefit plan during an open enrollment period under the New Albany Floyd County Schools benefit plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with New Albany Floyd County Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through New Albany Floyd County Schools changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 4, 2023
Name of Entity/Sender:	New Albany Floyd County Schools / Whitney Missi HR

CMS Form 10182-CC **Updated April 1, 2011**

Contact--Position/Office:	Whitney Missi-HR Benefits Specialist
Address:	2813 Grant Line Road New Albany, IN 47150
Phone Number:	812-542-2123