



FOCUS ON BENEFITS

Effective July 1, 2020



WAUTOMA
AREA SCHOOL DISTRICT

QUESTIONS

Nikki Van at (920) 787-7112 ext. 1303 or Vann@Wautoma.k12.wi.us

This piece is not a contract, but a summary of your benefits. Please refer to your contract (Summary Plan Description or Certificate of Coverage(s)) for more detailed information. In case of conflict, your contract will prevail for all claim adjudication.

In this document

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 - Initial COBRA Notice
 - Notice of Exchange
 - Medicare Part D Coverage Notice
 - HIPAA Notice of Privacy Practices
 - CHIP Notice
 - WHCRA Notice

FOCUS ON BENEFITS 2020 - 2021

Wautoma Area School District

What's new?

Open enrollment for the 2020-2021 plan year ended on May 31, 2020.

This document includes the benefits and enrollment information at the Wautoma Area School District for the 2020 – 2021 plan year. We encourage you to take the time to read through and explore your benefits options. At the District, we value our employees and are committed to providing a comprehensive and competitive benefits package.

As you know, health care costs continue to exceed CPI increases annually. The District's health plan is not immune to these higher costs and our health plan experienced an elevated level of claims activity this past year. Due to this larger than normal growth in our claims, the District received a 15% health plan renewal from WCA-GHT effective July 1, 2020.

To make the most of your health care dollars, please remember the following:

- Virtual visits are available for both primary care and mental health through Teladoc. See additional information on Teladoc on pages 7 & 8.
- If you need an MRI, consider utilizing a SmartChoice MRI facility to save money for both you and the District. You'll receive high quality imaging services at an economical cost and earn a \$50 Visa gift card also. Check out page 9 for more details.
- Use the Check Drug Cost tool available at www.Caremark.com. You'll be able to do a side-by-side comparison of your medications to see where you could be saving. See page 6 for additional tips on saving money on prescriptions.

Certain benefits you elect require an employee contribution. In some cases, those contributions will be deducted from your check on a pre-tax basis; in other cases the deduction will be made after-tax to avoid certain tax consequences to you and the company. For taxability of benefit elections, please contact Nikki Van at [920.787.7112](tel:920.787.7112) or Vann@Wautoma.k12.wi.us.

Required notices are located at the end of this document.

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Wautoma Area School District

HEALTH PLAN SUMMARY

Effective July 1, 2020, we will continue to offer a health plan through WCA Group Health Trust for all benefit-eligible employees.

About the Health Plan: Preventive care is covered at 100% and no deductible applies. For other services, this plan requires a deductible before eligible services are paid at 100%.

Features	In-Network	Out-of-Network
Deductible <i>per plan year</i>	\$3,500 /single \$7,000/family	\$7,000 /single \$14,000/family
Out-of-Pocket Max <i>per plan year</i>	\$3,500 /single \$7,000/family	\$7,500 /single \$15,000/family
Physician Services <i>Office visits, Urgent Care Clinic, Retail Health Clinics</i>	You pay 0% after deductible	You pay 20% after deductible
Preventive Services <i>Well child, Immunizations, Screenings</i>	You pay \$0	You pay 20% after deductible
Mental/Behavioral/ Substance Use	You pay 0% after deductible	You pay 20% after deductible
Chiropractic/Physical/ Occupational/Speech Therapies	You pay 0% after deductible	You pay 20% after deductible
Ambulance	You pay 0% after deductible	You pay 20% after deductible
Hospital	You pay 0% after deductible	You pay 20% after deductible
Prescription Drugs at a Participating Pharmacy	You pay 0% after deductible	
<i>Retail or Mail Order (up to 90 days)</i>		
<i>Specialty Drugs (limited to 30 days)</i>		

Please review your benefit plan summary document for more detailed coverage information.



BALANCE BILLING

The amount that the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Always use an in-network provider for the highest coverage of services.

SUMMARY OF BENEFITS COVERAGE

Refer to your summary of benefit coverage (SBC) for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

QUESTIONS?

Call customer service at [800.826.9781](tel:800.826.9781) or call the phone number on the back of your ID card or visit www.umar.com. If UMR cannot answer your question, call WCA-GHT at [800.236.6885](tel:800.236.6885).

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Health Plan Premiums

The Wautoma Area School District pays the majority of your health plan premiums. Generally, your share of the premiums is 12.5% while the District pays 87.5% of the premium. However, this amount may vary depending on your employee classification and your full-time equivalency. If you have any questions on your premium contribution, contact Nikki Van in the District Office.

Finding an In-network Provider

If you need help finding an in-network provider, you can either call Customer Service at [800.926.9781](tel:800.926.9781) or login to www.umar.com. Instructions for finding a provider on the UMR website are:

- Go to www.umar.com
- Click on "Find a provider"
- Type in "UnitedHealthcare Choice Plus Network" and click on "Search"
- For a medical provider:
 - At the bottom of the next page, click on "View Providers"
 - Enter the location by zip code or city & state and click "Continue"
 - On the next page, search by name, specialty, facility, clinic, or medical group
- For a behavioral health provider:
 - Click on Behavioral health directory
 - Enter the location by zip code or city & state and click "Continue"
 - Search by name, expertise, condition, phone or program



PRIOR AUTHORIZATION REQUIRED FOR CERTAIN HEALTH SERVICES

WCA-GHT requires that certain services have a prior authorization before the service is received. Failure to get a prior authorization could impose a penalty of up to \$250 per occurrence. A representative list of these health services is listed below.

- Inpatient (IP) Hospitalizations, including but not limited to the following:
 - IP maternity stays longer than 48 hours for a normal delivery & 96 hours for a C-section
 - IP behavioral health (acute care)
 - Transplant & Transplant-related services
 - Skilled Nursing Facility (extended care facilities)
 - Residential Treatment
- Durable Medical Equipment over \$1,000 in cost (excludes braces and orthotics)
- Clinical Trials & services related to the clinical trials
- Dialysis
- Chemotherapy (all diagnoses)
- Infusion Therapy (over \$1,000 per infusion treatment)

If using a PPO provider, your provider's office will usually assist with the prior authorization paperwork, but remember that since the financial responsibility lies with the member, you will want to check with your provider to assure that the prior authorization was approved. If using a non-PPO provider, you must call UMR to obtain authorization. Also please call UMR with any questions concerning prior authorization, especially if you are using a non-PPO provider.

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Prescription Drug Coverage through CVS Caremark

You can access and manage your prescription drug benefits online through Caremark's website. It's important to note that you will not be able to access the CVS Caremark website through the UMR website. You must go to the Caremark website and create a user name and password. Here are six tips to help you save time and money on your medications:

Register at www.Caremark.com. That way you can keep up to date on new and unique ways to save.

Be sure any retail pharmacy you use is in your network. Network pharmacies are included in your prescription plan to help keep costs low. If you fill out-of-network you will have to pay 100% of the cost. Find a network pharmacy before you fill at www.Caremark.com.

Know which medications are covered. Your plan's list of covered medications can help you and your doctor find the most cost-effective drug option. Find your plan's list of covered medications at www.Caremark.com.

Use the *Check Drug Cost* tool available at www.Caremark.com. You'll be able to do a side-by-side comparison of your medications to see where you could be saving.

Ask your doctor if there is a generic option for your brand-name medication. Proven just as safe and effective as brand-name medications, generics may be an affordable option for your treatment.

Have 90-day supplies delivered by mail. Save on medications you take regularly when you fill in 90-day supplies through our mail service pharmacy. 90-day supplies typically cost less, and there's no extra cost for shipping. Visit www.Caremark.com/mail-service to get started.



NO-COST PREVENTIVE DRUGS

Your health plan now offers certain preventive drug benefits at no cost to you. This means you don't have to pay a copay* or coinsurance, even if you haven't met your deductible. These no-cost benefits are part of the Affordable Care Act (ACA). They include:

- Medicine and supplements to prevent certain health conditions for adults, women and children
- Medicine and products for quitting smoking or chewing tobacco (tobacco cessation)
- Medicine used prior to screenings for certain health conditions in adults
- Vaccines and immunizations to prevent certain illnesses in infants, children and adults
- Contraceptives for women

Note that your doctor must write a prescription for these preventive services to be covered by your plan, even if they are listed as over-the-counter.

Please contact 866.818.6911 or to www.caremark.com for more information.

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HEALTH PLAN VALUE-ADDED PROVISIONS

Cost Savings Teladoc Telemedicine Visits

Teladoc is a new way to access qualified doctors in a convenient and cost-effective means. Through Teladoc you have access 24/7/365 to board-certified doctors via the convenience of phone, video, or mobile app visits. It's an affordable alternative to costly urgent care and emergency room visits when you need care now.

Teladoc providers are practicing primary care physicians (PCPs), pediatricians, and family medicine physicians with an average 20 years of experience. These providers are licensed in Wisconsin and credentialed every three years, meeting NCQA standards.

While Teladoc doesn't not replace your local primary care physician, it is a convenient and affordable option for quality care when:

- When you need care right now
- If you're considering the emergency room or urgent care for a non-emergency issue
- Are on vacation, on a business trip, or away from home
- Need a short term prescription refill (prescriptions sent to your pharmacy of choice)

Talk to a doctor anytime via Teladoc. Go online at www.teladoc.com, or call 800.835.2362 (800.TELADOC), or download the app from either the App Store or Google play.

Teladoc Now Offers Behavioral Health Visits – New Option

Taking care of your mental health is an important part of your overall well-being. With Teladoc's Behavioral Health, adults 18 years and older can get care for anxiety, depression, grief, family issues, and more. Choose to see a psychiatrist, social worker, or therapist and establish an ongoing relationship.

Scheduling a phone or video visit with a therapist is easy and convenient; instructions are in the right-side panel on this page. You can make an appointment seven days a week, from 7 a.m. to 9 p.m. local time. Appointments are confirmed within 72 hours.



GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Sore throat
- Respiratory infections
- Skin problems
- Pink eye
- And more!

HOW TO SCHEDULE A THERAPY VISIT


Below are the steps need to schedule a Teladoc therapy appointment:

- Register your Teladoc account via the web or app or log-in to your account if you are already registered
- Request a visit
- Answer a few questions
- Select your therapist
- Request a time for your appointment

Teladoc Information (Cont'd)

Get started with Teladoc

It's quick and easy to set up your account online. Simply visit the Teladoc® website, click "Set up account" and then follow the instructions below.



STEP 1:

The basics

Provide a little information about yourself to confirm your eligibility.

STEP 2:

Do you have a username?

Select "yes" or "no". Not everyone has a username to activate their Teladoc account, so don't worry about selecting "No."

STEP 3:

How do you have Teladoc?

Teladoc is an exclusive service that is not available to everyone. Typically, Teladoc is offered by your employer or health plan. You may also have a Teladoc promo code or a Teladoc ID card. If you're not sure you have Teladoc, call the number below for assistance over the phone.



SET UP YOUR TELADOC ACCOUNT

STEP 1 – CREATE ACCOUNT

Use your phone, the app, or the Teladoc website to create an account and quickly complete your medical history. See the screenshot to the left for additional information about creating an account.

STEP 2 – REQUEST A VISIT

Use your device to request a visit and a Teladoc doctor will contact you at the requested time.

STEP 3 – FEEL BETTER

Your doctor will diagnose your symptoms and even prescribe medicine, if needed.

Talk to a doctor anytime for free!

 [Teladoc.com](https://www.teladoc.com)

 [Facebook.com/Teladoc](https://www.facebook.com/Teladoc)

 **1-800-TELADOC (835-2362)**

 [Teladoc.com/mobile](https://www.teladoc.com/mobile)

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Wautoma Area School District

smart choice MRI PREFERRED PROVIDER

WCA Group Health Trust

Did you know: on average an MRI costs \$2,600?

A simple solution to control health plan costs



Every MRI, \$600 or less

The price includes the cost of the scan, any contrast needed & the radiologist interpretation of results. For WCA GHT members, there are no out of pocket fees at time of service.



Leading GE Technology

We use state-of-the-art GE MRI technology, the same technology you'd find in leading hospitals.



Dedicated Appointment Times

Preferred morning, evening and weekend appointments for WCA GHT members.



Cleveland Clinic Radiology

All exams are interpreted by sub-specialized, board-certified radiologists from the Cleveland Clinic.

Schedule Your MRI Today

1. Get an MRI Order

Let your doctor know that you want to go to Smart Choice MRI.

2. Schedule

Call (844) 633-3674 or visit smartchoiceMRI.com

3. Mention

WCA GHT members receive priority access to appointment times.

WCA GHT offers a \$50 Visa Gift Card to spend on anything you wish when you have your MRI exam done at Smart Choice MRI!

Choose from five convenient Wisconsin locations:

Appleton - Kenosha - Milwaukee - Richfield - Waukesha



Milwaukee

1621 Miller Park Way
West Milwaukee, WI 53214
I-94 & Miller Park Way

Richfield

3010 Helsan Dr.
Richfield, WI 53076
I-41 & WI-145

Waukesha

2005 Silvermail Rd.
Waukesha, WI 53072
I-94 & Grandview Blvd.

Kenosha

7224 118th Ave.
Kenosha, WI 53142
I-94 & US 50

Appleton

3525 Calumet St.
Appleton, WI 54915
WI-441 & Calumet St.

Questions?

call (844) 633 - 3674 or visit smartchoiceMRI.com

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Wautoma Area School District

You deserve an explanation



An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about your claims.

Among the more important things included on your EOB are:

- The service you received
- How much the service cost
- How much you may owe, if anything
- A notes section that explains the meaning of any special codes

- A section that shows how close you are to meeting any plan maximums

There is a second page that includes contact numbers if you have questions. It also tells you how to file an appeal if you want a claim decision reviewed.

Service Description	Dates of Service From To	Amount Billed	Amount Paid	Co-Pay Amount	Allowable Amount	Plan Benefits Amount	Amount Due
Emergency Care	02-01-16 02-01-16	\$500.00	\$300.00	\$20.00	\$280.00	\$280.00	\$20.00
Totals		\$500.00	\$300.00	\$20.00	\$280.00	\$280.00	\$20.00

The type of service you received

How much the service cost

How much your benefits plan paid

How much you may owe (if anything)

Your code definition

Your plan maximums and how close you are to meeting them

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CHECK OUT THE UMR MEMBER PORTAL AT

WWW.MEMBER.UMR.COM/

Member

How can we help you?

- View site tour
- Find a form
- Tools and resources
- Report fraud

- Find a provider
- Healthy "U" presentations
- Health education library
- Glossary
- And more!

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Wautoma Area School District

HEALTH SAVINGS ACCOUNT ADVANTAGES

District contributions to your HSA

The District contributes the following to your HSA annually (amounts may be prorated depending on your hire date):

Coverage Tier	Annual Basis
Single	\$2,750
Family	\$5,500

Is a health savings account right for me?

Like any health care option, an HSA has advantages and disadvantages. As you weigh your options, think about your budget and what health care you are likely to need in the next year.

If you are generally healthy and want to save for future health care expenses, an HSA may be an attractive choice. Or if you are near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement.

On the other hand, if you think you might need expensive medical care in the next year and would find it hard to meet a high deductible, an HSA might not be your best option.

Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage. If you are covered on the High Deductible Health Plan (HDHP), but you are also covered on another group health plan (such as your spouse's group plan) that is not an HDHP, you would also be ineligible to make contributions to an HSA.

Also an HSA is not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.

Please notify HR if you become enrolled in Medicare or other disqualifying coverage so that HSA contributions can be terminated and avoid adverse tax consequences for you. If you are eligible for, but not enrolled in, Medicare please contact HR before deciding to continue any HSA contributions.

TOP REASONS TO HAVE AN HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep.

Rollover — Your HSA contributions accumulate and rollover each year. Account funds remain yours until spent (no "use it or lose it rule").

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests and prescription medications.

Reduced Insurance Premiums — The cost of coverage under a qualified HDHP is typically lower than the other plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax-deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, however, taxes will be imposed.)

Safety Net — AN HSA has no "use it or lose it" restrictions, so balances can be built up to use for major medical events.

Coverage for the "Extras" — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over a certain amount may be invested.

Empowerment — Take control of your health care decisions, including which providers you want to use, to ensure your health care dollars are spent wisely.

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How much can you put in the health savings accounts?

Maximum contributions are \$3,550 for single coverage and \$7,100 for family coverage for 2020 (employer and employee contributions combined). Catch-up contributions may be made annually for those 55 and older, up to \$1,000.

Note that if you fund a new HSA with the max contributions, you will need to be enrolled in the HSA for the entire plan year, or penalties apply.

How do I use the HSA to pay for medical care?

It is rather simple. Here are the steps:

1. You and/or the company puts money into the HSA.
2. You or a dependent receives medical services.
3. A bill for medical services is submitted as a claim.
4. You receive an Explanation of Benefits for the service, which will reflect the amount due to the provider.
5. At this time you can choose to:
 - Use your HSA funds to pay the provider directly for the amount due
 - Pay the provider with personal funds and request reimbursement
 - Use your funds and save your HSA dollars for future medical expenses
6. Process repeats until deductible and out-of-pocket maximums are met, after which benefits are paid for the remaining plan year.
7. Refer to IRS Publication 969 on Qualified Medical Expenses for your HSA.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to wcaght.org to search for providers and clinics that offer the medical services you need at the best cost.

Can I withdraw money from an HSA for nonmedical expenses?

Yes, but if you withdraw funds for nonmedical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.

SPECIAL NOTE

IRS regulations for HSAs do not allow a person to have double coverage with another health insurance company. For employees who have coverage with another company along with the District's WCA-GHT/UMR Health Plan will be offered a Health Reimbursement Account (HRA) instead of an HSA. Vantage Flex is the third party administrator for our HRA program. The HRA is also \$2,750 for single coverage and \$5,500 for family coverage. Employees can get reimbursed for qualified medical expenses through the HRA. The HRA is the employee's to use as long as they are employed by Wautoma Area School District.

BE A SMART HEALTHCARE CONSUMER!



You have different care options to choose. Gaining a better understanding of your options now can help you save both time and money when you need to seek care. Options for treatment include:

Convenience Care, Online Care: Located inside of retail stores or online, visit these for common ailments like strep throat, pink eye, bladder infection, etc. Cost: \$

Doctor's Office: Staffed by doctor, PA and nurses, visit this for care of illnesses, injuries, preventive care, etc. Cost: \$\$

Urgent Care Clinic: Staffed by doctor, PA and nurses, visit this for care of minor illnesses or injuries that require immediate attention. Cost: \$\$\$

Emergency Room: Located inside of a hospital, visit this for serious illnesses, injuries or life-threatening issues, such as, chest pains, shortness of breath, burns, head injuries, etc. Cost: \$\$\$\$

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DENTAL PLAN SUMMARY

About the Dental Plan: This is a comprehensive plan for all dental services. The deductible does not apply to Diagnostic & Preventive Services. You may use any dentist for your dental services; however, using an in-network provider will reduce your out-of-pocket costs. See the next page for your network provider options.

Features	Benefits
Annual Maximum	\$1,000
Annual Deductible <i>Does not apply to preventive and diagnostics</i>	\$25/person; \$75/family
Diagnostic & Preventive <i>Exams & Cleanings</i>	You pay 0%
Basic Restorative Care <i>Amalgam & Resin Fillings</i>	You pay 0%
Oral Surgery <i>Simple Extractions</i>	You pay 0%
Endodontic Therapy <i>Root Canal</i>	You pay 0%
Periodontics <i>Gum disease</i>	You pay 0%
Major Restoratives <i>Resins, Crowns</i>	You pay 0%
Prosthetics	Not covered

Please review your plan summary document for more detailed coverage information.

Dental Plan Premiums: The Wautoma Area School District pays the majority of your dental premiums. Generally, your share of the premiums is 12.5% while the District pays 87.5% of the premium. However, this amount may vary depending on your employee classification and your full-time equivalency. If you have any questions on your premium contribution, contact Nikki Van in the District Office.



We offer the Delta Dental dental plan. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out-of-network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

CHECKUP PLUS PROVISION

The District's dental plan has a provision called CheckUp Plus. CheckUp Plus allows you to get diagnostic and preventive dental services without those costs getting applied to your individual deductible. That helps you make the most of your dental dollars.

INFORMATION ON THE GO!

Access your dental account information from your smartphone or mobile device with Dental Delta app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist
- Brush with toothbrush timer

AMPLIFON HEARING HEALTHCARE

As a Delta Dental member, you receive discounts and savings on hearing diagnostic testing, along with the guaranteed lowest pricing on hearing aids. Call 888.901.0132 or visit www.amplifonusa.com/deltadentalWI for information.

QUESTIONS?

Call customer service at 800.236.3712 or call the phone number on the back of your ID card or visit www.deltadentalwi.org.

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DELTA DENTAL NETWORK OF PROVIDERS

Network Savings Information

The District's dental plan through Delta Dental of Wisconsin offers employees the freedom to choose who they want for their dental provider; those choices are described below.

Delta Dental PPO Network – offers the largest discounts off charges, but has a smaller network. Services provided by these dental providers will cost less than either the Delta Dental Premier network or out-of-network providers.

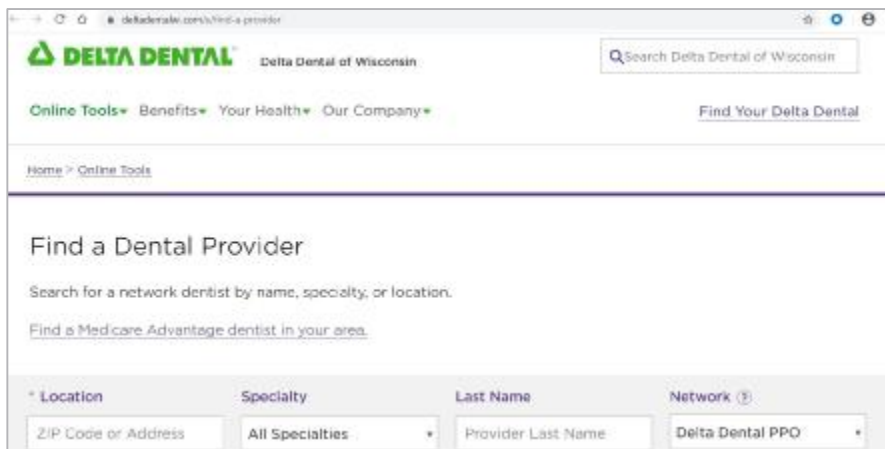
Delta Dental Premier Network – offers a very broad network of providers (nearly 90% of all the dentists in Wisconsin), but has a much smaller discount.

Out-of-Network Provider – has no discount off dental charges, but allows complete freedom of choice concerning the dental provider. These providers often charge more than allowed by Delta Dental and so the patient can be balance billed for the difference. Using out-of-network providers will cost more out-of-pocket than either of the two network providers.

Go to Delta Dental of Wisconsin's website at www.deltadentalwi.com/provider-search/ to locate a dentist near you or to check and see if your current dentist is in one of the Delta Dental networks.

Finding a Dentist

Go to Delta Dental of Wisconsin's website at <https://www.deltadentalwi.com/s/find-a-provider> to locate a dentist near you or to check if your current dentist is in one of the Delta Dental networks.



The screenshot shows the Delta Dental of Wisconsin website's search interface. At the top, there is a search bar with the text "Search Delta Dental of Wisconsin". Below the search bar, there are navigation links for "Online Tools", "Benefits", "Your Health", and "Our Company". A "Find Your Delta Dental" link is also present. The main heading is "Find a Dental Provider". Below this, there is a search prompt: "Search for a network dentist by name, specialty, or location." and a link: "Find a Medicare Advantage dentist in your area." At the bottom, there are four search criteria: "Location" (with a dropdown for "ZIP Code or Address"), "Specialty" (with a dropdown for "All Specialties"), "Last Name" (with a text input for "Provider Last Name"), and "Network" (with a dropdown for "Delta Dental PPO").



SPECIAL PLAN PROVISION - DELTA DENTAL'S EVIDENCE-BASED INTEGRATED CARE PLAN

Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP) is included in the District's dental policy. EBICP provides for expanded benefits for persons with medical conditions that have oral health implications, such as:

- Diabetes
- Pregnancy
- Specific heart conditions that pose a risk of certain types of infection
- Kidney failure or dialysis
- Suppressed immune system
- Cancer therapy
- Periodontal disease

EBICP's unique enrollment mechanism requires no medical claims be filed.

EBICP requires self-enrollment by the patient or his/her dentist at www.deltadentalwi.com, or by calling 800.236.3712. Learn more at www.deltadentalwi.com/your-health/medical-conditions.

DELTA DENTAL VISION DISCOUNT CARD

Not to confuse this Delta Dental benefit with the DeltaVision Voluntary Plan, we want to explain that as a Delta Dental member, you are eligible for a vision discount card. By using the card, you can receive discounts and savings on eye care services & materials, such as exams, eyewear, & contacts. For a provider directory, go to <https://www.deltadentalwi.com/s/find-a-deltavision-provider-near-you> (select the Access network). The program is through Eye Med Vision Care and is not an insurance plan, but a discount program. The Delta Vision Discount Card cannot be combined with the DeltaVision Vision Plan.

See the next page for more details on the DeltaVision Voluntary Vision Plan.

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VOLUNTARY VISION SUMMARY

Our vision plan is offered through Delta Vision utilizing the EyeMed network. This is a comprehensive plan for all vision services.

You may use any provider for your vision services; however, using an in-network provider will reduce your out-of-pocket costs.

Features	In-Network	Out-of-Network Reimbursement
Eye Exam (once every 12 months)	You pay \$20	Up to \$35
Plastic Lenses (once every 12 months)		
<i>Single</i>	You pay \$20	Up to \$25
<i>Bifocal</i>	You pay \$20	Up to \$40
<i>Trifocal</i>	You pay \$20	Up to \$55
<i>Standard Progressive</i>	You pay \$85	Not covered
Lens Options		
<i>UV, Tint, Coating</i>	You pay \$15	Not covered
<i>Polycarbonate</i>	You pay \$40	Not covered
<i>Anti-Reflective</i>	You pay \$45	Not covered
Frames (once every 24 months)	\$130 allowance, then 20% off balance	Up to \$65
Contacts – In lieu of glasses, (once every 12 months)	Allowance covers materials only	
<i>Conventional</i>	\$120 allowance, then 15% of balance	Up to \$96
<i>Disposable</i>	\$120 allowance	Up to \$96
<i>Medically necessary</i>	Paid in full	Up to \$200

Please review your plan summary document for more detailed coverage information.



Always use an in-network provider to obtain the highest level of benefits.

When accessing care out-of-network, you receive an amount that the provider will pay up to. You are then responsible for the difference.

Note: This is a voluntary plan, participation is optional. If you elect participation in the vision plan, please realize that you are locked-in for the entire plan year and cannot change your election until the next open enrollment. You may waive this coverage if you don't need eyeglasses or contacts.

PROVIDER LISTING

For an up-to-date listing of EyeMed providers in your area, visit the Delta website at <https://www.deltadentalwi.com/s/find-a-deltavision-provider-near-you> or call EyeMed's Customer Care Center at 844.848.7090.

QUESTIONS?

Call Member Services at 844.848.7090 or visit <https://eyemed.com/en-us>.

VISION PLAN PREMIUMS

This is a voluntary plan, meaning you pay 100% of the premiums.

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ANCILLARY PLANS

LIFE AND AD&D INSURANCE THROUGH ETF

You have an enrollment opportunity for life insurance, including accidental death & dismemberment, coverage through the Wisconsin Public Employers Group Life Insurance Program administered by Employee Trust Funds (ETF) if you:

- Are under age 70;
- Are enrolled in the WRS with the District; and
- Apply within 30 days of eligibility.

Additionally, you have an opportunity to enroll in Basic coverage or to increase employee coverage by one level (1x earnings) or add one or two units of Spouse & Dependent coverage if you apply within 30 days of one of the following family status changes:

- Marriage;
- Birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

If you do not enroll for all available coverage when you are eligible, you may apply for future coverage through Evidence of Insurability.

Through this program you can elect up to five times your salary in term life and AD&D insurance. Briefly stated, the ETF Life/AD&D Insurance is offered in units that are defined as your highest prior calendar year's earnings, rounded up to the next thousand. Units by type of life/AD&D coverage are explained below:

- Basic Plan coverage is one unit of coverage.
- Supplemental Plan coverage is one unit of coverage.
- Additional Plan provides up to three units of coverage.
- Spouse and Dependent Plan provides up to two units of coverage for your spouse or domestic partner and all qualifying dependent(s). Each unit of coverage provides \$10,000 in spouse (maximum of \$20,000) coverage and \$5,000 (maximum of \$10,000) coverage for each qualifying dependent.

Contact ETF at 877.533.5020 or online at <http://etf.wi.gov/> for more information.

RETIREMENT SAVINGS



WISCONSIN RETIREMENT SYSTEM (WRS) THROUGH ETF

For eligible employees, the total contribution rate to WRS for 2020 is 13.5% of gross wages; half of that is paid by the District and the other half is paid by the employee via "pre-tax" deductions.

TAX-SHELTERED ANNUITY PLAN 403(B)

All employees are eligible to participate in a 403(b) tax-deferred annuity plan. This plan is also called a Tax-Sheltered Annuity (TSA). It allows you to set additional money for retirement. The District offers two different vendors for the 403(b): Thrivent and WEA.

The employee pays the total cost of the 403(b) tax-deferred annuity contribution. There is no District contribution. Please see Nikki Van if you would like to enroll.

WISCONSIN'S SECTION 457(B) DEFERRED COMPENSATION PROGRAM

All employees are eligible to participate in a 457(b) tax-deferred plan administered by WDC. The employee will pay the total cost of the 457(b) tax-deferred contribution. There is no District contribution. Check with Nikki Van if you would like to enroll.

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VOLUNTARY SHORT-TERM DISABILITY

The Voluntary Short-Term Disability Program is through Voya Financial. If you did not sign up for Short-Term Disability when you were first eligible, you will need to provide medical evidence of insurability before coverage is effective.

You can receive 66.67% of your earnings (up to a maximum weekly benefit of \$504) in the event of a qualifying disability claim. Short-Term Disability benefits are payable from the first day of an accident or the third day of an illness.

This benefit is voluntary and so you pay 100% of the premium via payroll deductions. Check with Nikki Van in the District Office for your applicable premium.

LONG-TERM DISABILITY

The Long-Term Disability Program is through National Insurance Services (NIS) in conjunction with Madison National Life Insurance Company. You may receive 75% of your pre-disability earnings (classified as your base pay) in the event of a qualifying disability claim. Benefits may begin after 90 days. There is no cost to you for this benefit since it is paid 100% by the District on your behalf. Note that you are automatically enrolled in this benefit.

WEA PROPERTY & CASUALTY INSURANCE

If you have your home, auto, and/or other individual insurance policies through WEA, then you can have those premiums paid via payroll deduction. See Nikki Van for additional information.

AFLAC VOLUNTARY POLICIES

If interested, please contact Julie Friedl at julie.friedl@gmail.com for additional information on AFLAC policies. Payment for these policies can be handled via payroll deductions.



IDENTITY THEFT ASSISTANCE

Through Madison National Life Insurance Company and NIS, there is also an identity theft assistance program available. If you are a victim of identity theft, the *MyIDCare Identity Theft Recovery* specialist will provide concierge-style service every step of the way. Their expertise will offer peace of mind and save valuable time during this stressful process.

MyIDCare can be contacted at 855.205.6010 or online at <https://app.myidcare.com/account-creation/NIS>.

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Wautoma Area School District

VALUE – ADDED SERVICES

Resources for Your Total Health Support from National Insurance Services (NIS) and Madison National Life Insurance Company.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Access to masters-degreed counselors 24-hours a day through a toll-free number.

The EAP Process

When you access the EAP, Morneau Shepell counselors listen and take action toward finding solutions. The next step may include meeting with a mental health counselor for up to three face-to-face visits, negotiating health insurance benefits or referrals to community resources for legal and financial services.

Everyday life can be stressful and can affect your health, well-being and performance. Fortunately, our Employee Assistance Program can aid in finding solutions. When facing personal problems, you might struggle with where to turn for help. The first step is usually the hardest, and guidance is often the key. That's why we offer an EAP. An EAP offers a confidential place to find the answers that work for you. Receive compassionate expertise and confidential help for a variety of health concerns, including:

- Depression
- Alcohol and drug addiction
- Financial or legal concerns
- Stress management
- Child and elder care
- Marital difficulties
- Parenting concerns
- Problem gambling
- Family conflict
- Memorial planning assistance

Call [866.451.5465](tel:866.451.5465) or visit www.niseap.com (password – NISenhanced).



Remember no problem is too large or too small. Contact the EAP for assistance at [866.451.5465](tel:866.451.5465)

CLAIMANT ASSISTANCE

Furthermore, when you have Long-Term Disability insurance through NIS, there are special services available via a Claimant Assist program. These services help guide and counsel claimants and their immediate family members during a disability .

Claimant Assist services are available at [866.472.2734](tel:866.472.2734).

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NEXT STEPS

OPEN ENROLLMENT FOR THE 2020 – 2021 PLAN YEAR ENDED ON MAY 31, 2020

Note: You can enroll or make changes in the health, dental, and/or voluntary vision plan at your time of hire, during open enrollment, or when you have a qualifying life event.

During either open enrollment or your initial enrollment, please review your benefit information in order to decide what is best for you & your family. Complete the required enrollment forms as a newly hired employee or during open enrollment. Your enrollment should be done in a timely manner so your coverage is not delayed. For a qualifying life event, you must request enrollment within 30 days after marriage, birth, adoption, placement for adoption, loss of other coverage.

If you are currently enrolled in the health, dental, and/or voluntary vision plans and do not have any changes, you will be automatically re-enrolled at your current coverage status. No forms are needed.

HAVE A QUESTION ON YOUR BENEFITS?

After your benefits enrollment, the most effective and efficient way of getting your specific benefit questions answered is to contact the appropriate Customer Service line. Contact information for the various vendors is listed in the side panel on this page.

Making the call yourself allows you to make sure that your question is completely understood directly by the carrier. And likewise, you will hear the answer yourself directly from the carrier.

If you cannot get your question(s) answered to your satisfaction by the appropriate Customer Service Center, then please contact:

Nikki Van

920.787.7112, ext. 1303 or Vann@Wautoma.k12.wi.us

Note that forms are located in Skyward WebPosts. Additionally, Nikki can supply you with any needed process information or forms that cannot be obtained from the Customer Service line(s) or Skyward WebPosts.

VENDOR QUICK LINKS

Health Plan

UMR (call first) 800.826.9781
www.umar.com

WCA-GHT (call second) 800.236.6885

For precertification 866.494.4502

Prescription Drug Questions

CVS Caremark 866.818.6911
www.caremark.com

Teladoc – Telemedicine Services

800.835.2362
www.teladoc.com

Dental Plan

DELTA DENTAL OF WI 800.236.3712
www.deltadentalwi.com

Voluntary Vision Plan

DeltaVision EyeMed 844.848.7090
Eyemed.com

HRA Plan

Vantage Flex, LLC 800.871.9011, ext. :
(ask for Julie Nichols)

Life/AD&D and WRS

ETF 877.533.5020
<http://eftf.wi.gov>

Short-Term Disability

VOYA 888.305.0602

Long-Term Disability

NIS 800.627.3660
www.nisbenefits.com

Employee Assistance Program (EAP)

MORNEAU SHEPELL 866.451.5465
www.niseap.com

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WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. HIPAA Portability Notice
2. Initial COBRA Notice
3. Notice of Exchange
4. Medicare Part D Coverage Notice
5. HIPAA Notice of Privacy Practices
6. CHIP Notice
7. WHCRA Notice

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HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company's Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

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 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.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact Nikki Van, [920-787-7112 ext. 1303](tel:920-787-7112), Vann@Wautoma.k12.wi.us.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse, and dependent children when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless the Plan sponsor has chosen to subsidize the cost of COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice to: Nikki Van, 920-787-7112 ext. 1303, Vann@Wautoma.k12.wi.us

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How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children .

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

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Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the individual health insurance carriers, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

If you have questions

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

Keep your plan informed of address changes

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

Plan contact information

Nikki Van, 920.787.7112 ext. 1303, Vann@Wautoma.k12.wi.us

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NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General information

When key parts of the health care law took effect in 2014, there began 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 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 began 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 credit¹.

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 Nikki Van, 920.787.7112 ext. 1303, Vann@Wautoma.k12.wi.us.

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. 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.

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.

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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.

3. Employer name: Wautoma Area School District
4. Employer Identification Number (EIN): 39-6005075
5. Employer address: 556 S Cambridge St
6. Employer phone number: 920-787-7112
7. City: Wautoma
8. State: WI
9. ZIP code: 54982-8120
10. Who can we contact about employee health coverage at this job? Nikki Van
11. Phone number (if different from above): 920-787-7112 ext. 1303
12. Email address: Vann@Wautoma.k12.wi.us

Here is some basic information about health coverage offered by this employer

As your employer, we offer a health plan to:

All employees. Eligible employees are: You, when You are regularly employed 6 hours per day/ school year by the Wautoma Area School District.

With respect to dependents:

We do offer coverage. Eligible dependents are:

1. A Covered Employee's legal spouse.
2. A Covered Employee's married or unmarried child whose age is less than the limiting age and is a: natural born, blood-related child; step-child; legally adopted child; child placed in the Employee's legal guardianship by court order; or a child placed with the Employee for the purpose of adoption and for which the Employee has a legal obligation to provide full or partial support.

The limiting age for a Dependent child is the last day of the month in which the child reaches age 26.

Coverage may be extended (beyond age 26) for a Dependent child if all of the following requirements are met:

- a. the Dependent child is a full-time student, regardless of age, and
- b. the Dependent child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and
- c. the Dependent child was under age 27 when called to federal active duty.

Dependent children who are eligible for this extension, covered under the Plan and drop below full-time student status due to Injury or Sickness may be covered until the earliest of the following, when certification of the medical need for the leave is provided to the Plan by the child's attending Qualified Practitioner:

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- a. the date the child's coverage would terminate for reasons other than not being a full-time student,
- b. 12 months from the date the child was no longer a full-time student.

Dependent children who are eligible for this extension will be covered for up to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

3. A Covered Employee's grandchild, as long as the Employee's Covered Dependent child or legal ward, who is the parent of the grandchild, is not yet 18 years old, or marries, whichever occurs first.

A Covered Dependent child who attains a limiting age while covered under this Plan will remain eligible for benefits if the Plan Administrator determines that all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;
2. The child is incapable of self-sustaining employment because of intellectual disability or physical handicap;
3. The child is chiefly dependent on the Covered Employee for support and maintenance; and
4. The child never married.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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MEDICARE PART D CREDITABLE/NON-CREDITABLE COVERAGE NOTICE

Important notice from Wautoma Area School District about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Wautoma Area School District 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. Wautoma Area School District has determined that the prescription drug coverage offered by the Wautoma Area School District Health 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 through 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.

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Wautoma Area School District

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 Wautoma Area School District 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 if this coverage through Wautoma Area School District changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (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 800-772-1213 (TTY 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:	July 1, 2020
Name of Entity/Sender:	Wautoma Area School District
Contact--Position/Office:	HR Manager
Address:	556 S Cambridge St, Wautoma, WI 54982-8120
Phone Number:	920.787.7112

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Wautoma Area School District

NOTICE OF PRIVACY PRACTICE

Your information. Your rights. Our responsibilities.

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

Your rights

You have the right to:

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

Your choices

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

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

Our uses and disclosures

We may use and share information as we:

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

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Wautoma Area School District

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling [877-696-6775](tel:877-696-6775) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

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Wautoma Area School District

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

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

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

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Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the department of health and human services if it wants to see that we're complying with federal privacy law.

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

CHANGES TO THE TERMS OF THIS NOTICE

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

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Wautoma Area School District

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 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 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, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
FLORIDA – Medicaid Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/index.cfm/page/2693 Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
GEORGIA – Medicaid Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711

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<p>INDIANA – Medicaid</p> <p>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</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>
<p>IOWA – Medicaid – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563</p>	<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other insurance?”] Phone: 1-800-657-3739</p>
<p>KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792/4884</p>	<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855 632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>	<p>OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p>NEW HAMPSHIRE – Medicaid</p> <p>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</p>	<p>PENNSYLVANIA – Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>

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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	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	TEXAS – Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493
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
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	VERMONT – Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WASHINGTON – Medicaid Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022	WYOMING – Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
WEST VIRGINIA – Medicaid Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	

To see if any other states have added a premium assistance program since January 31, 2020, 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

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Wautoma Area School District

NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women's Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women's Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the company's health insurance carrier directly for more information on your rights under the Women's Health and Cancer Rights Act.

This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

Your employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.

Information provided by Associated Benefits and Risk Consulting. Associated Benefits and Risk Consulting is a marketing name used by Associated Financial Group, LLC (d/b/a ABRC Insurance Solutions in California).