WCSC Open Enrollment

Benefits don't have to be scary!

October 16 – October 30

Abbie Redmon, Superintendent
Walter Lambert, Director of Student Services
Jason Fischer, Director of Learning

Warrick County School Corporation

Todd Armstrong, Assistant Superintendent
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Administration Building 300 E. Gum Street, Boonville, IN 47601 (812) 897-6036

TO: All Health Insurance Benefit-Eligible Employees/Retirees of WCSC
FROM: Todd A. Armstrong, Assistant Superintendent
DATE: October 1, 2024
SUBJECT: 2025 Health, Vision, and Dental Insurance Renewal

SIGNIFICANT: All those who have declined the benefit in the past and still do not wish to enroll are finished at this point. Everyone else must complete at least one page of paperwork. Please read for details.

Health and Vision are combined. Dental is separate Form! H.S.A is separate Form!

Things to Know

1) The dental insurance renewal is included with this packet. There are no changes to the dental plan benefits and the cost increase is 2% for 2025. If you complete no dental paperwork, you keep what you currently have. If you want to add, delete, or make a change to the dental plan, see Paramount Dental Enrollment form and instructions.

2) The attached rate sheet depicts the cost comparison for each available health insurance plan design. Note the semi-monthly payroll deduction for each plan status within each plan option.

3) As in the past, each of the plan designs has a plan # assigned to it. The first option is Plan 5 ($3,300 deductible increased from $3,200), and the second option is Plan 6 ($5,000 deductible). Both plans are qualified high-deductible health plans and eligible for H.S.A. Please see memo regarding H.S.A. enrollment.

4) Study the Summary of Benefits pages that summarize and compare the benefits of each of the plan options currently available within our Anthem health plan. The benefits have remained unchanged. These documents should be used as a tool to help make your selection among plan options.

5) Please utilize the "Sample Scenarios" page to aid your comparisons and assist in your decision making.

6) Although your vision plan premium is already embedded in your health premium, it is not with Anthem. It is with Vision Services Plan (VSP). See attached VSP Benefit Summary for details.

7) Open enrollment is scheduled for October 16 through October 30, 2024. Please turn in your paperwork to your principal, manager, or Amanda Vollman no later than 1:00 p.m. on October 30, 2024.

8) If you are not actively-at-work or a retiree, please return documents by Friday, November 1, 2024 to Amanda Vollman at 300 E. Gum Street, Boonville, IN 47601.

9) Amanda Vollman will be visiting each school to provide support and answer questions that individuals may have regarding their health insurance selection. **Her building schedule is included with this document.**

10) Feel free to utilize the Corporation Health and Wellness Fitness Facility to de-stress and stay healthy (see flyer)!

11) **Completion of all sections in their entirety is imperative. Failure to complete the forms correctly and completely may cause delays in your coverage.** All forms are also available on our website under, "Employee," "Business Office," "Insurance Plans & Notification."

Process

The following, as well as the FAQ document, will help you decide what paperwork you need to complete. Some sections of the forms have been completed or modified in an effort to ease their completion.

A) Everyone continuing coverage, enrolling for coverage, or canceling coverage MUST **complete** the "Anthem Plan Selection Form." Please print your name in addition to signing the form. **If you have no changes in dependent(s)/spouse and are not dropping coverage, you are finished (See H.S.A memo). If you are dropping coverage entirely, see Letter E.**

B) If you are ADDING a dependent(s)/spouse to the plan, complete the "Enrollment Application" form for that individual(s) only. Select "Add Dependent" in Section 2. Complete other applicable sections.

C) If you are DELETING a dependent(s)/spouse from the plan, complete the "Employee Change Form." Select "Cancel Dependent" in Section 2. Complete other applicable sections.

D) If you did not have WCSC health insurance in 2024 but are enrolling for 2025, complete the "Enrollment Application." "Annual Open Enrollment" has already been selected in Section 2. Complete the remainder of applicable sections.

E) If you are dropping the health plan entirely, complete the "Employee Change Form." Be sure to check "Waiving Coverage" in Section 2. Complete other applicable sections.

Both plan design options are qualified HDHP. If you plan on utilizing salary reduction to contribute to your H.S.A., complete the H.S.A. Salary Reduction Agreement that is included with this packet. A new form must be completed each year.

Please be aware that you are not eligible for an HDHP with H.S.A if you are receiving coverage under another health plan that is not an HDHP. (You can however, select HDHP without an H.S.A).

Anthem continues to be "open access," so in order to find out if your doctors are "in-network," do the following if you have internet access:

Visit:	www.anthem.com;
Select:	"Find Care"
Select:	State or National Directory
Answer:	"Select a Plan" with **Blue Access PPO**

If you do not have internet access, contact member services at (800)-295-4119.

Special Note: If you are a dual-member enrollee and your selection is the HDHP Option Plan #6, the Corporation will contribute $1,956 for MS plans to your HSA.

The maximum contribution to a "single" H.S.A. for 2025 is $4,300, and for all others, the maximum contribution for 2025 is $8,550. Do note that there is a $1,000 (per year) catch-up available for account holders that are 55 or older before December 1 of plan year.

While the Affordable Care Act allows parents to add their adult children (up to age 26) to their health plans, the IRS does not allow for spending H.S.A. funds to pay for medical bills of **non-dependent** children (not claimed on parent's tax return) (20% penalty plus taxable).

This entire packet is available on the Warrick County School Corporation website under "Employee", "Business Office."

WARRICK COUNTY SCHOOL CORPORATION

2025 Health Insurance Renewal

Not too shabby for the past 5 years!!

The following is a summary of the plan design costs available for 2025. Use this information to select your health plan from among the two (2) options. Plan # 6 is exactly the same as 2024.Plan # 5 deductible has been increased (legislatively) to $3,300.The maximum out of pocket remains the same. Pay special attention to the column labeled "2025 Semi-Monthly Employee Contribution." This is the amount that is deducted from your paycheck 24 times from December 2024 through November 2025 (2 of 26 paychecks do not have deductions).

Anthem Blue Access PPO BA H.S.A. Option E1 RX T8 ($3,300 Deductible)

	Established Monthly Premium	Months	Yrly Premium	Employer Cont.	Employee Due	Monthly Employee Contribution	2021 Semi-Monthly Employee Contribution	2022 Semi-Monthly Employee Contribution	2023 Semi-Monthly Employee Contribution	2024 Semi-Monthly Employee Contribution (Dec-Nov)	2025 Semi-Monthly Employee Contribution (Dec-Nov)	2024 Semi-Monthly Employee Contribution Dual-Members	2025 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$1,035	12	$12,416	$9,800	$2,616	$218	$96	$96	$99	$99	**$109**	NA	**NA**
Emp/Sp	$1,975	12	$23,700	$14,000	$9,700	$808	$386	$385	$393	$393	**$404**	$176	**$187**
Emp/Child	$2,059	12	$24,708	$14,000	$10,708	$892	$427	$426	$435	$435	**$446**	NA	**NA**
Family	$2,415	12	$28,976	$17,000	$11,976	$998	$474	$471	$487	$487	**$499**	$395	**$407**

Anthem Blue Access PPO BA H.S.A. Option E4 RX T8 ($5,000 Deductible)

	Established Monthly Premium	Months	Yrly Premium	Employer Cont.	Employee Due	Monthly Employee Contribution	2021 Semi-Monthly Employee Contribution	2022 Semi-Monthly Employee Contribution	2023 Semi-Monthly Employee Contribution	2024 Semi-Monthly Employee Contribution (Dec-Nov)	2025 Semi-Monthly Employee Contribution (Dec-Nov)	2024 Semi-Monthly Employee Contribution Dual-Members	2025 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$841	12	$10,088	$9,800	$288	$24	$0.01	$0.01	$5	$5	**$12**	NA	**NA**
Emp/Sp	$1,437	12	$17,244	$14,000	$3,244	$270	$124	$121	$128	$128	**$135**	$0	**$0**
Emp/Child	$1,471	12	$17,652	$14,000	$3,652	$304	$139	$137	$145	$145	**$152**	NA	**NA**
Family	$1,737	12	$20,840	$17,000	$3,840	$320	$153	$148	$154	$154	**$160**	$62	**$68**

a) Please complete a thorough comparison of the benefits that each plan provides (see attached summaries and examples).

b) Because both options are HDHP's, neither you nor your spouse, regardless of employer, may use a Section 125 Generation II medical reimbursement account (A.K.A. flexible savings account) to satisfy the required deductible.

c) Corporation contribution for dual members is $19,200 and is used in dual member column.

d) $.01/month is the minimum employee contribution required.

e) Both HDHP plans qualify for H.S.A.

If you do not have an H.S.A., you will be given opportunity to set one up.

Sample Scenarios to Consider (Being provided as a "Simplistic" view)

This is not an attempt to advise anyone which plan design he/she should select.

But, it is important to remember that paying premium is a guarantee of money spent vs. the chance that you don't pay all of a deductible.

Each family's case is "individualized" as specialty drugs, rehabilitation, therapy, and unique circumstances exist.

These examples only account for In-network services. Also, balanced billing etc. is not accounted for.

This does not account for dual employee contributions.

Obviously, if your health issues are able to be handled through our available clinics, you only need to compare premiums.

Also remember that if you do not have $ in your H.S.A., you can reimburse yourself from it as money is deposited in it.

Moreover, most employees will spend among the spectrum between premiums and maximums...these are near "worst-case" scenarios.

Pay special attention to the last column (Amount Employee will pay after Copays). This represents the cost of the plan after paying employee share of premiums, deductibles, copays etc.

Also realize that the GREATEST POTENTIAL SAVINGS is with the $5000 HDHP.

Also realize that the less $ spent towards deductible automatically means "lesser-premium" plan is even less expensive.

Single Plan Comparison

Plan Design	Semi-monthly Payment	# of Payments	Total Employee Paid Premium	Credit for Employer Contribution	Maximum Deductible	Premium + Deductible		Co-insurance to Max Out-of-Pocket	Amount Employee will spend without Copays	Maximum Co-pays	Amount Employee will pay after Copays	
H.S.A. Plan 5	$109.00	24	**$2,616.00**		$3,300.00	$5,916.00	Pay 0% after deductible	$0.00	$5,916.00	800	$6,716.00	
H.S.A. Plan 6	$12.00	24	**$288.00**		$5,000.00	$5,288.00	Pay 0% after deductible	$0.00	$5,288.00	950	$6,238.00	*

Family Plan Comparison

Plan Design	Semi-monthly Payment	# of Payments	Total Employee Paid Premium	Credit for Employer Contribution	Maximum Deductible	Premium + Deductible		Co-insurance to Max Out-of-Pocket	Amount Employee will spend without Copays	Maximum Co-pays	Amount Employee will pay after Copays	
H.S.A. Plan 5	$499.00	24	**$11,976.00**		$6,600.00	$18,576.00	Pay 0% after deductible	$0.00	$18,576.00	1600	$20,176.00	
H.S.A. Plan 6	$160.00	24	**$3,840.00**		$10,000.00	$13,840.00	Pay 0% after deductible	$0.00	$13,840.00	1900	$15,740.00	*

*** Again, potential savings for those that only need clinic care during the course of the year is the difference between the premiums. This can be quite substantial!**

+ This indicates additional cost for copays that employee pays during the year.

FAQs for Open Enrollment

- **What is Open Enrollment?**

Answer: Open enrollment is your chance to add coverage or make changes to your current Anthem Medical or Paramount Dental Coverage.

- **Who can help me if I have questions about my benefits package?**

Answer: Please contact Amanda Vollman in the Benefits Office at avollman@warrick.k12.in.us or call 812-897-6038. Email is the fastest way to receive a response. Phone calls will be answered when in the office and not out in the buildings.

- **How can I find out more about the plans?**

Answer: Please refer to the Open Enrollment Packet. The digital version of the packet can be found by clicking this link: www.warrick.k12.in.us/572331_3

- **What do I do if I keep everything the same with my medical insurance and I do not wish to make changes?**

Answer: In order to renew your current medical plan and keep everything the same, you **MUST** sign and date the **ANTHEM PLAN SELECTION FORM**. If you have an HSA deduction that you would like to keep the same, you **MUST** complete a new **HSA Salary Reduction** form each year.

- **What if I am a new teacher/Employee and I just enrolled within the last few months, do I need to do anything?**

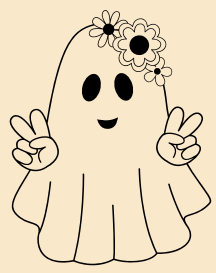
Answer: Yes, see answer above for keeping everything the same.

- What if my spouse and I are both employed with WCSC? Do both of us need to complete paperwork?

Answer: No, only the carrier of your plan needs to complete the **ANTHEM PLAN SELECTION** form and **HSA Salary Reduction form** (if applicable).

- **What form do I need to complete if I would like to elect WCSC's health insurance?**

Answer: Please complete the **ANTHEM PLAN SELECTION form** and **ANTHEM ENROLLMENT FORM**.



- **What is the effective date if I elect coverage during Open Enrollment?**

Answer: **January 1, 2025**.

- **How do I add my spouse or child(ren) to my insurance plan?**

Answer: Please complete the **Anthem Plan Selection** form & **ANTHEM ENROLLMENT FORM.**

- **How do I drop the WCSC Insurance plan?**

Answer: Please complete the **Anthem Plan Selection form** & **ANTHEM CHANGE FORM**.

- **Can I elect/drop/ or change my Paramount Dental Coverage at open enrollment?**

Answer: Yes. The dental form is in the packet.

FAQs for Open Enrollment

- **What if I want to switch from Plan 5 ($3,300 deductible) to Plan 6 ($5,000 deductible)?**

Answer: Please complete the Anthem Plan Selection form, check the appropriate boxes, and sign and date the form.

- **What is the Maximum HSA Contribution this year?**

Answer:

- Family: $8,550.00 ($712.50 per month)
- Single: $4300.00 ($358.33 per month)

*If you are over 55 - $1,000 catch-up (please refer to HSA Packet for more info)

- **If I want to keep my HSA deduction the same as in 2024, how can I find out what I am currently contributing to my HSA?**

Answer: You can find this on your paycheck stub. The HSA deduction is on the 2nd pay of each month. You can also find this on your UMB online account.

- **Can I change my HSA deduction amount with American Fidelity?**
- **Answer:** No, this can only be changed with WCSC on the Salary Reduction form.

- **Am I eligible for a health savings account if I do not elect insurance with WCSC?**

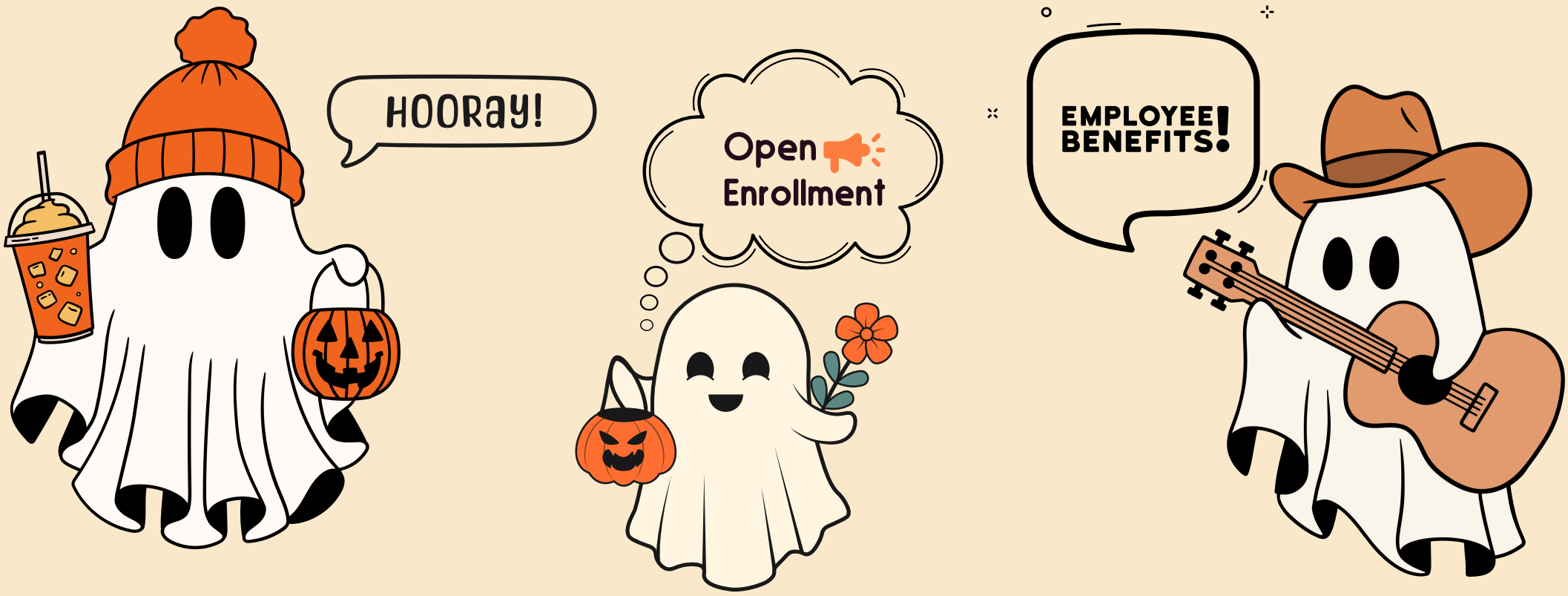
Answer: No, you must be enrolled in one of our health plans to elect an HSA deduction.

- What is the deadline to turn in enrollment forms?

Answer: October 30, 2024, before 1:00 p.m. to the principal, secretary, or directly to Amanda Vollman in the benefits office.

- **Does WCSC have an Employee Assistance Program?**

Answer: Yes. Please see the **Guidance Resources** flyer at the back of your packet. The EAP Program is available to all employees (PT & FT) and includes emotional support, work and lifestyle support, legal guidance, financial resources, and digital support.



Warrick County School Corporation Open Enrollment Checklist

To confirm that you have finished the open enrollment process, please review the following checklist:

☐ **Anthem Plan Selection Form**

Mandatory for current health plan members or new enrollees.
Ensure to indicate the appropriate choices.

☐ **Anthem Enrollment form**

Are you a new enrollee? Or do you want to add a dependent or spouse? If so, the Anthem Enrollment form is what you need to complete.

☐ **Anthem Change form**

Are you wanting to drop the Anthem Plan entirely? Or drop a dependent? Or do you need to drop your spouse? if you answered yes to any of these questions, this is the form you will complete..

☐ **H.S.A Salary Reduction Agreement**

Did you have an HSA deduction in 2024 that you want to continue? Do you want to elect a new H.S.A. deduction for 2025? If you answered yes, please complete this form.
If you don't make your 2025 HSA election, your deductions will stop.

☐ **Open H.S.A. account**

Do you have a new H.S.A election this year? If so, you need to open your account.
https://hsa.umb.com/
Enroll for a new HSA at the link above. Visit the WCSC Benefits page for more info.

☐ **Paramount Dental Enrollment Application**

Are you enrolling, in the dental plan? Adding a dependent or spouse to your current plan? Or dropping the dental plan entirely. This is the form you need.

☐ **Have all the forms been completed?**

Double-check all forms for accurate information, including DOBs, SSNs, and full legal names.

All forms are available in .pdf format on the WCSC Benefits page

For any questions or assistance needed, reach out to Amanda Vollman at avollman@warrick.k12.in.us or 812-897-6038.

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

IPST – Warrick County School Corp – Effective: 01-01-2025
Your Plan: Anthem Blue Access PPO HSA $3300 Deductible

Your Network: Blue Access

Plan #5 - $3,3000 deductible

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$3,300 person / $6,600 family	$6,000 person / $12,000 family
Overall Out-of-Pocket Limit	$4,000 person / $8,000 family	$12,000 person / $24,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 15 visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge after deductible is met	30% coinsurance after deductible is met
Surgery	No charge after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	No charge after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physician and other services *including surgeon fees*	No charge after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period,* *Coverage for physical therapy is limited to 20 visits per benefit period.* *Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	Covered as In-Network
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$10 copay per prescription after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$30 copay per prescription after deductible is met (retail) and $75 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription after deductible is met (retail) and $180 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $200 per prescription after deductible is met (retail and home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network Providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Indiana Department of Insurance (IN DOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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Questions: (833) 578-4441 or visit us at www.anthem.com

Your Plan: Anthem Blue Access PPO HSA $3300 Deductible

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Plan # 6 - $5,000 deductible

IPST – Warrick County School Corp – Effective: 01-01-2025
Your Plan: Anthem Blue Access PPO HSA $5000 Deductible

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$5,000 person / $10,000 family	$10,000 person / $20,000 family
Overall Out-of-Pocket Limit	$5,950 person / $11,900 family	$20,000 person / $40,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge after deductible is met	30% coinsurance after deductible is met
Surgery	No charge after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care	No charge after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period,* *Coverage for physical therapy is limited to 20 visits per benefit period.* *Coverage for speech therapy is limited to 20 visits per benefit period*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	Covered as In-Network
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Prescription Drug Coverage **Network:** ***Base*** **Drug List:** ***National*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$10 copay per prescription after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$30 copay per prescription after deductible is met (retail) and $75 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription after deductible is met (retail) and $180 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $200 per prescription after deductible is met (retail and home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network Providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible / copayment / coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Indiana Department of Insurance (IN DOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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Questions: (833) 578-4441 or visit us at www.anthem.com

Your Plan: Anthem Blue Access PPO HSA $5000 Deductible

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

A Look at Your VSP Vision Coverage

With VSP and WARRICK COUNTY SCHOOL CORPORATION, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

WARRICK COUNTY SCHOOL CORPORATION and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$5 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	See frame and lenses
FRAME†	• $250 Enhanced Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
VSP LIGHTCARE™+	• $250 featured frame brands allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$10	Every other calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on Featured Frame Brands. Go to **vsp.com/offers** for details. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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Classification: Restricted

Anthem Plan Selection Form

Everyone continuing coverage, enrolling for coverage, or canceling coverage must complete this form. Please complete each applicable section. Be sure to sign this document.

After selecting one of the HDHP's (H.S.A. qualified), please review the information for your contributions to the H.S.A.

Date: _____ Location: _____

☐ I am keeping everything the same. Skip to Signature

Current Plan Design: (Check 1 if applicable) **(Information is available on pay stub)**

☐ Plan Design 1 Option Plan 5 ($3200 deductible)

☐ Plan Design 2 Option Plan 6 ($5000 deductible)

☐ Not currently on WCSC health insurance plan

Current Plan Selection (Check 1 if applicable)

☐ Single ☐ Member/Children

☐ Member/Spouse ☐ Family

2025 Plan Design Selection: (Check 1 if applicable)

☐ Plan Design 1 Option Plan 5 ($**3300** deductible)

☐ Plan Design 2 Option Plan 6 ($5000 deductible)

☐ Dropping plan entirely

2025 Plan Selection (Check 1 if applicable)

☐ Single ☐ Member/Children

☐ Member/Spouse ☐ Family

Employee Signature: _____

Printed Name: _____

Are you a dual-enrollee? (Your spouse is also a FT Benefited Employee with WCSC. The CARRIER of the plan will sign above - list your spouse below)

If "Yes," please list spouse's name. If "No," leave blank.

Spouse Name: _____

REMEMBER: If you have a change in **Plan Selection** (not Design), you must complete additional paperwork!

Enrollment Application
Group size 51+ eligible employees

Anthem BlueCross BlueShield

Anthem Life

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name	Employer address			
WARRICK COUNTY SCHOOL CORPORATION	300 E. GUM STREET P.O. BOX 809 BOONVILLE, IN 47601			
Group no. 00228586	Sub-group no.			Employee no./Dept. name

SECTION 2: REASON FOR APPLICATION - Required

☐ New enrollment ☑ Annual open enrollment (N/A to Life)			☐ Add dependent (Fill in Section 3)

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date				
0 1 0 1 2 0 2 5	☐ Marriage ☐ Birth	☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation)	☐ Loss of coverage (reason) _____ ☐ Other_____	☐ Termed employment

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.	**Type of coverage**
☐ HSA PPO $3300 Deductible ☐ HSA PPO $5000 Deductible	☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)

Sex	Marital status	Height	Weight	Home phone	Business phone	Email address
☐ M ☐ F	☐ Single ☐ Married ☐ Divorced					

Address	City	State	ZIP code	County

Retired	Disabled	Hospitalized	Occupation	Full-time hire date	Hours working per week	Income reported by
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				☐ W2 ☐ 1099 ☐ Other_____

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Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employee name _____ Social security no. _____

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner

Last name	First name	M.I.	Social security no. (required)

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Spouse ☐ Domestic Partner	☐ Yes ☐ No (If yes, give reason)

If spouse/DP address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage ☐ Yes ☐ No (If yes,attach legal documentation)

If dependent address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage ☐ Yes ☐ No (If yes, attach legal documentation)

If dependent address is different than employee, please provide full address

SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No **If yes, complete below.**

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No **If yes, complete below.**

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

Employee name _____ Social security no._____

SECTION 9: PRIOR HEALTH COVERAGE - Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.

Have you been covered by Anthem within the past two (2) years ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy termed
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years ☐ Yes ☐ No		
List prior carrier(s)	Date policy in effect	Date policy termed

Please check the type of prior coverage

☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason:

☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other
☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature X	Date

Employee Change Form

Anthem BlueCross BlueShield

Anthem Life

INSTRUCTIONS:

Please complete this form ONLY if you are making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the Anthem "Enrollment Application" instead of this form.

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing **www.anthem.com**.

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name	Employer address			
WARRICK COUNTY SCHOOL CORPORATION	300 E. GUM STREET P.O. BOX 809 BOONVILLE, IN 47601			
Group no.	Sub-group no.			Employee no./Dept. name
00228586				

SECTION 2: REASON FOR CHANGE - Required. Please be sure to provide date of event.

Event date: 0 1 0 1 2 0 2 5

- ☐ Address
- ☐ Name change
- ☐ Benefit change
- ☐ Cancel dependent
- ☐ Conversion
- ☐ Change Life beneficiary
- ☐ Change Life classification
- ☐ Other_____
- ☐ Enrollment in Medicare (Fill in Section 7)
- ☐ Waiving coverage (Fill in Section 10)

SECTION 3: PLAN/TYPE OF COVERAGE

Medical If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.	**Type of coverage**
☐ HSA PPO $3300 Deductible ☐ HSA PPO $5000 Deductible	☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

SECTION 4: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)

Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Divorced	Height	Weight	Home phone	Email address	Hours worked per week

Address	City	State	ZIP code	County

SECTION 5: FAMILY INFORMATION – Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.

Spouse/Domestic Partner

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no. (required)
Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Spouse ☐ Domestic Partner	If spouse/DP address is different than employee, provide full address

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employee name _____ Social security no. _____

SECTION 5: FAMILY INFORMATION – CONTINUED. Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.

Dependent

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no.
Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Child ☐ Other_____	If dependent address is different than employee, provide full address

Dependent

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no.
Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Child ☐ Other_____	If dependent address is different than employee, provide full address

SECTION 7: OTHER HEALTH COVERAGE

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

SECTION 8: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

Employee name _____ Social security no._____

SECTION 8: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

SECTION 9: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 8 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date
X	

SECTION 10: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐	☐ ☐ ☐		☐ ☐ ☐	
☐	☐ ☐ ☐		☐ ☐ ☐	
☐	☐ ☐ ☐		☐ ☐ ☐	
☐	☐ ☐ ☐		☐ ☐ ☐	

Check all that apply:

☐ I have been given a chance to apply for Anthem Blue Cross and Blue Shield coverage, and after careful thought, I have decided not to take this offer. If I want to apply for coverage at a later date, I can, based on established methods. If I have decided not to take this offer of coverage for myself or my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents later, as long as I ask to sign up within 31 days after other coverage ends. If my dependent or I are late enrollees, we may be subject to pre-existing conditions restrictions or waiting periods set out in the group certificate. The pre-existing exclusion may not apply to dependents enrolled in the plan before their 19th birthday. Also, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents if I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may sign up under two more circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium aid program).

In these cases, I may be able to enroll myself and my dependents if I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given a chance to apply for the group life benefits offered by my employer/group. The benefits have been explained to me. I and/or my dependent(s) have decided not to join. My dependent(s) or I were not pressured by my employer/group, agent or life carrier, to say no to this coverage, but instead we chose to say no of our own accord. I agree that if I want to ask for coverage in the future, I may be asked to give proof of insurability at my own cost.

☐ Other:_____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature	Date
X	

UMB Healthcare Services

Quick Guide to HSAs

You own it!

The money in your HSA is always yours, even if you:

- ✓ change jobs
- ✓ switch health plans
- ✓ become unemployed
- ✓ retire

Your unused balance rolls over from year to year so you never lose the money.

Pay for the unexpected...

HSAs not only cover planned out-of-pocket costs but allow you to be better prepared financially when an unexpected injury or illness comes along.

HSA funds can be used for a variety of medical, dental, vision expenses and more.

See list of eligible expenses.

Ways to Save on Taxes[1]

1. **Tax-free deposits**[1] Money contributed to your HSA is not taxed.
2. **Tax-free earnings** Interest and any investment earnings grow tax-free.
3. **Tax-free withdrawals** for qualified medical expenses.

How it works

To make HSA contributions you must:

- Be covered by an HSA Qualified High Deductible Health Plan (QHDHP)
- Not be enrolled in Medicare (any part)
- Not be claimed as a tax dependent on someone else's taxes
- Have no other non-permissible coverage

HSA Contributions

PLAN TYPE	2025
Individual	$4,300
Family	$8,550

If you are age 55 or older, you may contribute an additional $1,000.

Invest[2] for the future

Learn more about UMB HSA investments[2].

HSAs can be used similar to traditional retirement accounts, allowing you to invest money in mutual funds,[2] like a 401(k) or traditional IRA.

You can invest in your HSA when:

Deposit balance = $1,000 + purchased investment amount for fund(s)

FOR MORE INFORMATION:

UMB.com/HSA

866.520.4HSA (4472)

[1] *All mention of taxes is made in reference to federal tax law. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. Please check with each state's tax laws to determine the tax treatment of HSA contributions or consult your tax adviser. Neither UMB Bank, n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice. Withdrawals for non-qualified expenses are subject to income taxes and a possible additional 20% penalty (penalty not applicable if you are over age 65).*

[2] INVESTMENTS IN SECURITIES THROUGH AN HSA INVESTMENT ACCOUNT ARE: NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

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Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

UMB Healthcare Services

EMPLOYER NAME
Warrick County School Corporation

ENROLLMENT VERIFICATION NUMBER
THA0001 - 160368

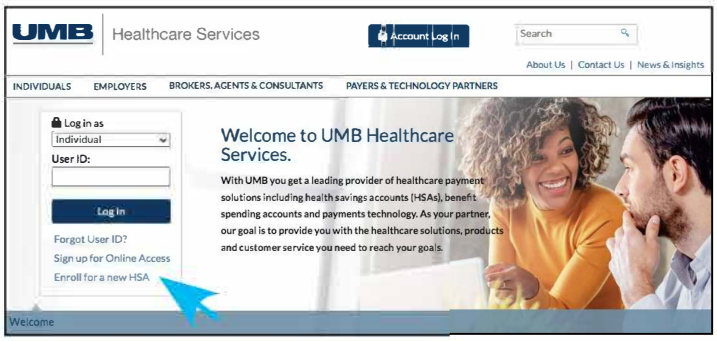
Follow these steps to open an account

UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SS# for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.



Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2, or go to **HSA.UMB.com** and click on "**Enroll for a new HSA**" and enter Enrollment Verification # provided by your employer.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note**: you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify & Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during the session, you will get one of the following screens:

Complete Enrollment
The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment
A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.
Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.

Once you have completed enrollment, within 5-7 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

ENROLLMENT VERIFICATION NUMBER
THA0001 - 160368

For questions or more information call 1.866.520.4HSA (4472).

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HSA Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Saving Account through your Cafeteria Plan. **Do Not Send Contributions With This Form.**

By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined by I.R.S. Code and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Account Holder Information (Please Print)

Name: (First) _____ (MI) _____ (Last) _____

HSA Contribution Election (This contribution will remain in effect until a new salary reduction agreement is submitted.)

I elect a MONTHLY contribution of $ _____ to my HSA effective 1/1/2025

Amount Date

Attention current MSA or HSA account holder with accounts at other financial institutions: Please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

HDHP Information

Beginning Coverage Date for HDHP: 1/1/2025

Check One: ☐ Single ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that the H.S.A. Authority is facilitating but not initiating the contribution.

This application is for the establishment of my individually owned Health Saving Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ Date: _____

Employer Signature

The employee's election of the Health Savings Account Contribution is acceptable as of the date shown below:

Authorized Signature: Amanda D. Vollman _____ Date: _____

Custodian

Warrick County School Corporation

Plan Service Provider

U.M.B. Bank

PARAMOUNT DENTAL INSURANCE

Dental insurance is offered with no contribution made by the corporation

SEMI-MONTHLY PREMIUMS (per pay period)
(AMOUNT PAID BY EMPLOYEE)

2025 Paramount Dental (HRI)

Single	$15.42 deduction per pay, 24 times/year
Employee + 1 Dependent	$31.73 deduction per pay, 24 times/year
Employee + Family	$52.12 deduction per pay, 24 times/year

Health Resources, Inc. dba Paramount Dental is proud to offer dental benefits for the employees of WCSC.

You may visit any dentist. However, to maximize the benefit of Paramount Dental's network discounts, select an In-Network provider to guard against balance billing. Balance billing from an out-of-network dentist can be significant and increase our out-of-pocket responsibility. You are always welcome to request Paramount's provider relations team to see a full list of Network Dentists, visit https://www.insuringsmiles.com/findadentist.

Here are the dental plan enrollment options for eligible employees:

- If there are no changes to an employee's dental plan, their coverage will renew automatically.
- For eligible employees who have not yet enrolled, you may sign up for the voluntary group dental plan during open enrollment.
- If you need to change or cancel coverage and are already enrolled, please complete the appropriate section of the Paramount Dental Enrollment Application. For example, if you need to terminate or update coverage for an employee, spouse/partner, or dependent, fill out the corresponding boxes on the application.
- All changes and enrollments are effective January 1, 2025.

Paramount Dental's autthorized Agent: Tom Southwood - 812-858-9900 or member services at 1-800-727-1444
Email: callcenter@insuringsmiles.com, FAX: 812-401-2096, Mail: PO BOX 659, Evansville, IN 47704-0659

PARAMOUNT DENTAL

Affiliate of ProMedica

Product Summary Guide for Warrick County School Corporation

DHO 6 (January - December)

Plan Annual Maximum Benefit:	$1,000	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Core build ups	Covered at 50%	Covered at 50%
Crowns – porcelain, ceramic, stainless steel	Covered at 50%	Covered at 50%
Fillings - silver or white (anterior and posterior teeth)	Covered at 50%	Covered at 50%
Protective restorations	Covered at 50%	Covered at 50%
Removable dentures	Covered at 50%	Covered at 50%
Endodontics & Periodontics		
Root canal therapy – anterior, posterior	Covered at 50%	Covered at 50%
Root canal therapy – retreatment	Covered at 50%	Covered at 50%
Scaling and root planing	Covered at 50%	Covered at 50%
Full mouth debridement	Covered at 50%	Covered at 50%
Periodontal maintenance	Covered at 50%	Covered at 50%
Oral Surgery		
Frenectomy	Covered at 50%	Covered at 50%
Simple extractions	Covered at 50%	Covered at 50%
Impactions	Covered at 50%	Covered at 50%
Surgical extractions	Covered at 50%	Covered at 50%
Miscellaneous		
Emergency palliative treatment	Covered at 50%	Covered at 50%
Anesthesia – general and IV sedation	Covered at 50%	Covered at 50%
Athletic mouthguards	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**
Lifetime Orthodontic Benefit (Dep. Child):	**$1,000**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment

Interceptive Orthodontic Treatment

Comprehensive Orthodontic Treatment

Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terms of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling HRI at 800-727-1444.

To find a dentist visit: InsuringSmiles.com/FindADentist

PARAMOUNT DENTAL
Affiliate of ProMedica

OPEN ENROLLMENT
January 1, 2025
Effective Date

InsuringSmiles.com
PO Box 659 Evansville IN 47704-0659
Phone: (800) 727-1444 - Fax: (812) 424-2096

ENROLLMENT APPLICATION
ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:	Group Number: PLEASE CIRCLE ONE	Site Location / Cabinet:	DHO Plan:
Warrick County School Corp.	Certified or Non Certified	N/A	N/A

ADD	TERM	UPDATE
Coverage Effective Date:_____	Coverage Termination Date:_____	Event Date (if applicable):_____
☐ Open Enrollment	☐ Open Enrollment	☐ Name Change
☐ New Hire	☐ Employment Termination	☐ Social Security Number
☐ Coverage Lost	☐ Coverage Gained	☐ Date of Birth
☐ Marriage	☐ Death	☐ Address
☐ Divorced or Legal Separation	☐ Reduction of Hours Worked	☐ Coordination of Benefits
☐ Birth / Adoption	☐ Divorced or Legal Separation	☐ Disability
☐ COBRA (if applicable)	☐ Over Age Limit	☐ Full Time Student Status
	☐ No Longer Full Time Student	
	☐ COBRA (if applicable)	

EMPLOYEE ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental ☐ Waive	Social Security Number			Employee Hire Date	
		Last Name	First Name	MI	Birth Date	
		Home Address	City		State	Zip
SPOUSE / PARTNER ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental ☐ Waive	Social Security Number	Birth Date		Other Dental Coverage? ☐ Yes ☐ No	
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	
DEPENDENT ☐ Add ☐ Term ☐ Update	**PRODUCT** ☐ Dental ☐ Waive	Social Security Number	Birth Date	☐ Disability ☐ Full Time Student	Other Dental Coverage? ☐ Yes ☐ No	
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No	

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from by salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Employee_____ Date_____

Employer Benefits Administrator/Authorized Agent_____ Date_____

GuidanceResources®

Your Life. Your Work. Your Best.®

Your GuidanceResources® Program

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Life is challenging.

We can help.

Confidential 24/7 support.

ComPsych®
GuidanceResources® Worldwide

Services:

Confidential Emotional Support

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support

- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance

- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support

- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

24/7 Live Assistance:
Call: 800-344-9752
TRS: Dial 711

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: NYLGBS

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WARRICK COUNTY SCHOOL CORPORATION
FITNESS FACILITY

FACILITY GUIDELINES

The fitness facility is open to all WCSC Employees.

The facility is also opened to **ALL** dependents on WCSC Anthem Medical Plans.

You must sign a release before access is permitted.

For questions regarding the fitness facility, please contact the benefits office 812-897-6038.

WCSC 812-897-6038 930 W Main Street, Boonville, IN

Location	WCSC Benefits - Amanda Vollman (Health & Vision/Dental/HSA)	American Fidelity
Administration Building	October 15th, 18th, 21st - 6:00 am - 4:00 pm	November 12th & 13th
Boonville High School	October 23rd - 2:15 pm to 3:45 pm	October 16th - October 18th
Boonville Middle School	October 23rd - 12:45 pm to 2:00 pm	October 28th, 29th, 30th
Castle High School	October 16th - 12:45 pm - 3:30 pm	October 15th - October 17th
Castle North Middle	October 17th - 11:45 am - 1:00 pm	October 21st & 22nd
Castle South Middle	October 17th - 9:15 am - 11:00 am	October 23rd, 24th, 25th
Chandler	October 16th - 7:00 am - 8:30 am	October 17th & October 18th
Elberfeld	October 22nd - 7:30 am - 9:00 am	October 25th
John H. Castle	October 24th - 7:30 am - 9:00 am	October 23rd, 24th, 25th
Loge	October 23rd - 8:45 am - 10:00 am	October 15th & October 16th
Lynnville	October 22nd - 9:30 am - 11:00 am	October 22nd
Newburgh	October 16th - 10:45 am - 12:15 pm	October 31st & November 1st
Oakdale	October 23rd - 10:15 am - 12:00 pm	October 21st & 22nd
Sharon	October 16th - 9:00 am - 10:30 am	October 21st, 22nd, 23rd
Tecumseh Middle/High	October 22nd 11:45 am - 2:00 pm	October 23rd & 24th
Tennyson	October 24th - 12:00 pm - 1:30 pm	October 25th
Transportation/Maintenance	October 17th - 6:15 am - 7:00 am	October 24th & October 25th
Virtual		November 5th
Warrick Education Center	October 23rd - 7:30 am - 8:15 am	November 11th
Warrick Pathways and Career Center	October 28th - 9:30 am - 10:45 am	October 24th
Yankeetown	October 17th - 7:15 am - 9:00 am	October 15th

WCSC Open Enrollment encompasses the following:

*Health Insurance/Vision Insurance (adding coverage, maintaining current selections, making changes, adding or dropping dependents)

*Dental (adding the plan, making changes, adding or dropping dependents)

*Health Savings Account (2025 election - required if applicable or adding a new account)

Amanda Vollman will be your primary contact for all matters concerning Health/Vision, Dental and Health Savings Accounts. The enrollment packets will be in your buildings Mid-October.

American Fidelity manages our Section 125 (pre-tax benefits) program. All full-time employees are required to schedule a meeting with a representative to review and confirm their current **WCSC benefits**. While the purchase of supplemental coverage is optional, meeting with a representative is mandatory for all full-time employees.

Notice of Availability of

Important Documents

Warrick County School

Corporation

Dear Employee,

This notice is to inform you of the availability of **important benefit documents**. In addition to those documents you are provided upon enrollment, more details can be found in the summary plan description, summary of material modifications, insurance contracts and other supporting documents.

Warrick County School Corporation has created a website where all of these documents can be viewed.

LINK: WCSC Important Benefit Documents - Notifications

If you wish to receive a hard copy of this information, at no cost, please contact Amanda Vollman, Benefits Facilitator, with your preference.

Sincerely

Amanda D. Vollman

Amanda Vollman
Warrick County School Corporation
Benefits Facilitator
812-897-6038 phone
avollman@warrick.k12.in.us email

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

Important Notice from Warrick County School Corporation 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 Warrick County School Corporation 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. Warrick County School Corporation has determined that the prescription drug coverage offered by the Anthem Medical plan for the plan year 1/1/2024 – 12/31/2024 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, the following options may apply:

- You may stay in the Anthem Medical plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
  - During the Medicare prescription drug annual enrollment period, or
  - If you lose Anthem Medical plan creditable coverage.
- You may stay in the Anthem Medical plan and also enroll in a Medicare prescription drug plan. The Anthem Medical plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Anthem Medical plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Anthem Medical plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Warrick County School Corporation 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 Warrick County School Corporation changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2024
Name/Entity of Sender:	Warrick County School Corporation
Contact Position/Office:	Amanda Vollman, Benefits Facilitator
Address:	300 East Gum Street, Boonville, Indiana, United States, 47601
Phone Number:	(812) 897-0400

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

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

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
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 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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