Interlocal 619

SUMNER COUNTY EDUCATIONAL SERVICES

BENEFITS RESOURCE GUIDE

2025–2026

Scan for Benefits Review Video

Enroll Online Today!

boss.employeenavigator.com

HOSPITAL/FIXED INDEMNITY PLAN NOTICE

Important: Your employer offers fixed indemnity plans, which are NOT health insurance.
These plans included coverage offered through Aflac.

These fixed indemnity policies may pay you a limited dollar amount if you are sick or hospitalized. You are still responsible for paying the cost of your care.

- The payment you get is not based on the size of your medical bill.
- There might be a limit on how much the policies will pay each year.
- These policies are not a substitute for comprehensive health insurance.
- Since these policies are not health insurance, they do not have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit Healthcare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job or a family member's job, contact your employer.

Questions about these policies?
For questions or complaints about these policies, contact your State Department of Insurance. Find their number on the National Association of Insurance Commission's website (www.naic.org) under "Insurance Department." If you have these policies through your job, or a family member's job, contact the employer.

Disclaimer

This Benefits Resource Guide is designed to provide basic information regarding benefit plans and programs available to eligible employees of Sumner County Educational Services Interlocal 619. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee of [name of plan sponsor], or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Sumner County Educational Services Interlocal 619 reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

2025—2026

Sumner County Educational Services Interlocal 619 offers you and your eligible family members a comprehensive benefits program. This Benefit Guide provides information on the health and welfare benefit plans and programs available to eligible employees. Every reasonable effort has been made to ensure the accuracy of the information contained in this overview. However, in the event of discrepancy between the benefit provisions as described in this overview and the applicable documents, the provisions described in the plan documents will govern.

The QR Codes throughout the Guide will give you easy access to explore additional information about the benefits offered. You are encouraged to take the time to educate yourself about your options and choose the best coverage for you and your family.

Benefit Overview Video: Scan the QR code on the front of this benefit guide to access an audio-visual presentation of the benefits outlined in this benefit guide.

Benefits Information Access: Additional benefit Information is posted on the benefit portal, **Employee Navigator,** and is available for review prior to making your benefit elections. For copies of the Summary of Benefits and Coverage (SBC), Benefit Summaries, links to provider website and more, login to the Employee Navigator Portal at http://boss.employeenavigator.com

Employee Navigator

Medicare Prescription Drug Information: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Important information can be found in the Legal Notices of this benefit guide. Please read the notice carefully and keep it where you can find it. This notice has information about the prescription drug coverage offered by Sumner County Special Education Interlocal 619, through UnitedHealthcare and about your options (if applicable) under Medicare's prescription drug coverage.

In This Issue

Availability of Summary Health Information: Summary of Benefits and Coverage (SBC) for each deductible option are available to you on the Employee Navigator benefit system. You may request the SBC at anytime, free of charge, upon request. Requests should be directed to:
Benefit Office
2612 N. A Street | Wellington, KS 67152
(620) 326-8935

Eligibility | Enrolling

What's New for 2025—2026?

- **Plan year premiums**—medical, dental and vision premium changes
- **Medical Plans**—changes to the medical plan offerings
  - Option 1: $1,000 Deductible—Prescription drug copay changes for Tiers 2, 3, 4
  - Option 2: $3,500 Deductible –Changes to deductible amount, out-of-pocket maximum, office visit copays and prescription drug copay changes for Tiers 2, 3, 4
  - Option 3: $3,300 Qualified High Deductible Health Plan—this plan option has changed entirely. Option 3 is a Qualified High Deductible Health Plan. This means that allowed charges under the medical plan are subject to the deductible, including prescription drugs. This deductible is the amount you are responsible for paying out-of-pocket for healthcare services each year before your insurance starts to cover the expenses, with the exception of ACA Preventive Care Services.
- **Healthcare FSA**—annual maximum election increases to $3,300

Eligibility

Sumner County Interlocal offers a variety of benefits as part of the comprehensive benefit package. Eligibility is outlined below for each available benefit.

Benefit	Eligibility Requirement	Effective date of coverage
Medical	**Certified Employees**: All certified employees, contracted for at least 30-hours per week are eligible for medical insurance **Classified Employees**: All classified employees who are regularly scheduled to work at least 30 hours per week are eligible for medical insurance	**All Eligible Employees:** First of the month following date of hire/ eligibility
Dental Vision	**All Eligible Employees:** Employee must work 25 or more hours per week	**All Eligible Employees:** First of the month following date of hire/ eligibility
Health Care FSA Dependent Care FSA	**Certified Employees**: Same as Medical **Classified Employees** : Same as Medical	**All Eligible Employees:** First of the month following date of hire/ eligibility
Mutual of Omaha Benefits Short-term Disability Life Insurance	**All Eligible Employees:** Employee must work 25 or more hours per week	**All Eligible Employees:** First of the month following date of enrollment (enrollment must be completed within 30 days of your date of hire)
Aflac Benefits	**All Eligible Employees:** Employee must work 25 or more hours per week	**All Eligible Employees:** First of the month following date of hire/ eligibility

Eligible Dependents are defined as:

- Legal Spouse
- Children to age 26, including step, adopted and foster children, and any child you have legal guardianship or court-ordered custody. A child who is incapable of self-support due to handicap resulting from a physical condition or mental illness may be approved over the allowed age limit of 26.

Eligibility | Enrolling

Enrollment as a new hire must be completed through the online portal— Employee Navigator— within 30-days of your date of hire.

Employee Navigator

First-time User Account Registration

First Login and Account Setup:
For best results, please use Chrome to view the enrollment
Your Company Login address is:
http://boss.employeenavigator.com
When you first arrive, please click the link toward the bottom of the page for "Register as new user"

You will need to Create Your Account by completing the fields on the next page.

Please make certain your answers are the same as on file with HR
(try to use the spelling of your name from your paycheck)

⇒ Your "Company Identifier" is **SumnerCo**

Click **Next>**

For your username, please enter your email address
The password must be 6 digits long and must include both a number and a symbol

- You can click on "show it" to verify what you have typed

Click on the box next to "I agree with the terms of use" before proceeding

Click **Next>**

Once you have created your account you will see a welcome message. You can now re-login at the same login address: http://boss.employeenavigator.com by entering your new username (email) and you new password you set in Step 3.

See pages 5—6 of the benefit guide for additional Enrollment Guide instructions.

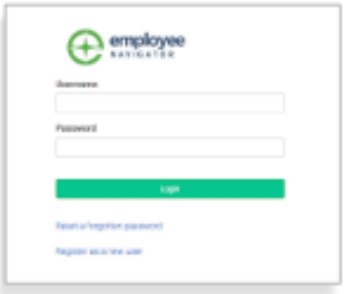
Qualified Life Events

IRS regulations require that, once enrolled, you may not change your benefit elections until the next open enrollment period. Outside of the Annual Open Enrollment Period, you may not make changes to your benefits unless you have certain qualified life event/change in status events. You may be asked to provide proof of the event. Qualified life events/changes in status events include:

- marriage, divorce, legal separation
- birth, adoption, legal guardianship or medical child-support order
- change in child's dependent status (i.e. reaching age 26)
- death of spouse, child or other qualified dependent
- change in residence due to an employment transfer for you or your spouse
- change in spouse's/child's benefits or employment status that impacts their eligibility status
- loss of group coverage at another group health plan or loss of eligibility through the Marketplace (loss of coverage due to failure to pay premiums does not constitute a mid-year election change)
- individual becomes eligible/ineligible for Medicaid/Medicare

PLEASE NOTE: You must notify the Benefits Office of any qualified life event within 30-days of the date of the qualified event if you are requesting a change to your benefits (or 60-days if the election change event is a special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP)**.** Changes requested due to a qualified life event must be consistent with the event.

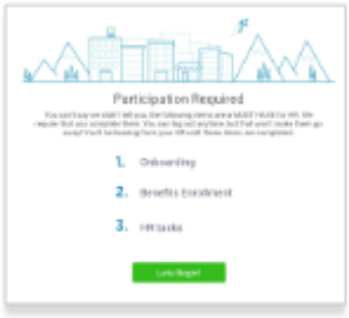
ENROLL IN YOUR BENEFITS: One step at a time



Step 1: Log In

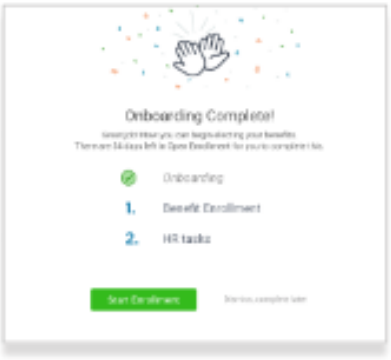
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

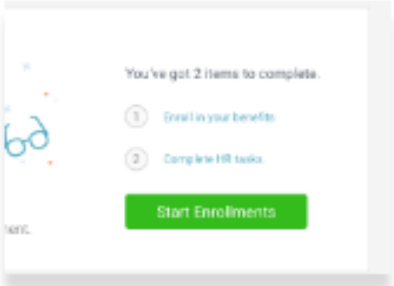


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit **"Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

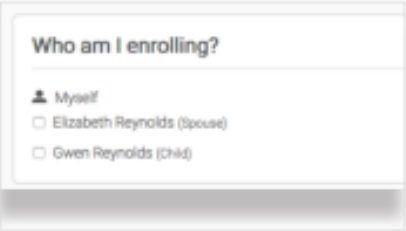
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

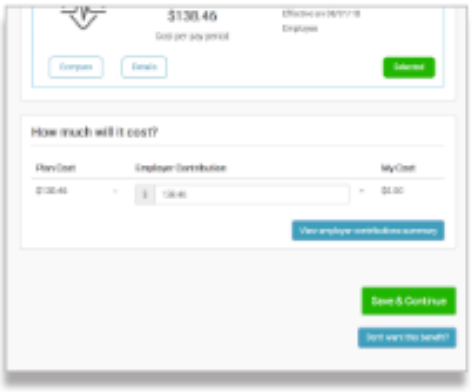
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.



Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

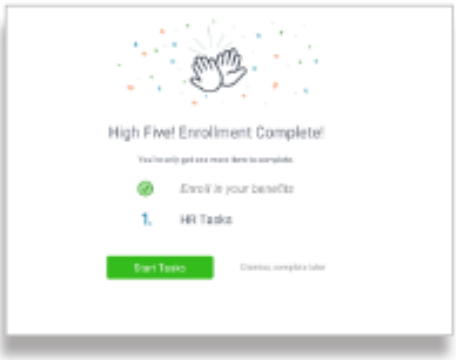
If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

2025—2026 Premiums

Eligible employees have the option under the Sumner County Educational Services Interlocal 619 Welfare Benefit Plan to elect medical, dental and vision coverage as well as the healthcare and dependent care flexible spending accounts. Your share of the premiums for these benefits will be deducted on a pre-tax basis. If you fail to elect coverage within the annual open enrollment or new hire eligibility period, you will be deemed to have voluntarily waived enrollment for the respective coverage for the entire year. Once made, pre-tax benefit elections are irrevocable and remain in effect for the plan year unless you have a Qualified Life Event/Status Change that allows you to make a change.

Medical Premiums

Employees who are eligible for medical insurance, and who enroll in a medical plan, will receive $420 toward the cost of their medical insurance premium.

The Employer-paid contribution is a defined medical benefit and you must be eligible and participate in the medical insurance to receive the benefit.

Medical Plan	Full Monthly premium	Monthly Board Contribution	Monthly Employee Cost
Option 1—$1,000 Deductible			
Employee Only	$645.20	$420.00	$225.20
Employee + Child(ren)	$1,225.87	$420.00	$805.87
Employee + Spouse	$1,354.93	$420.00	$934.93
Family	$1,935.60	$420.00	$1,515.60
Option 2—$3,500 Deductible			
Employee Only	$611.68	$420.00	$191.68
Employee + Child(ren)	$1,162.18	$420.00	$742.18
Employee + Spouse	$1,284.54	$420.00	$864.54
Family	$1,835.04	$420.00	$1,415.04
Option 3—$3,300 QHDHP			
Employee Only	$538.52	$420.00	$118.52
Employee + Child(ren)	$1,023.18	$420.00	$603.18
Employee + Spouse	$1,130.90	$420.00	$710.90
Family	$1,615.56	$420.00	$1,195.56

Medical Plan Option D—$3,300 Qualified High Deductible Health Plan

Option 3 is a Qualified High Deductible Health Plan. This means that allowed charges under the medical plan are subject to the deductible. This deductible is the amount you are responsible for paying out-of-pocket for healthcare services each year before your insurance starts to cover the expenses, with the exception of ACA Preventive Care Services.

Option 3 is a qualified plan for a Health Savings Account (HSA). You can open a Health Savings Account at many banks and credit unions. HSA's are tax-advantaged savings accounts that can accompany a QHDHP. There are other eligibility requirements that you should consider before contributing to an HSA. Funds contributed to an HSA must be used for qualified healthcare expenses. You should consult the IRS or a legal/tax advisor for tax inquiries. For more information refer to IRS Publication 969. For a complete list of eligible expenses, please visit http://www.irs.gov/pub/irs-pdf/p502.pdf.

2025—2026 Premiums

Dental Premiums

Full-time Certified employees who are eligible for dental insurance, and who enroll in a dental plan, will receive $16 toward the cost of their dental insurance premium. The Employer-paid contribution is a defined dental benefit and you must be eligible and participate in the dental insurance to receive the benefit.

DENTAL PLAN	Monthly Premium
Tier of Coverage	**Premium**
Employee Only	$30.61
Employee + Child(ren)	$61.55
Employee + Spouse	$60.76
Family	$103.81

Vision Premiums

Full-time Certified employees who are eligible for vison insurance, and who enroll in a vision plan, will receive $7 toward the cost of their vision insurance premium. The Employer-paid contribution is a defined vision benefit and you must be eligible and participate in the vision insurance to receive the benefit.

1/2 Certified do not receive Employer-paid contribution.

Vision PLAN	Monthly Premium
Tier of Coverage	**Premium**
Employee Only	$12.20
Employee + 1	$19.52
Employee + Children	$19.93
Family	$32.13

Vision: Employee +1 tier is either Employee + Spouse or Employee + 1 Child.

Please note, employees who receive less than 12 paychecks in a year will have an additional amount deducted from each paycheck to collect the premiums to pay for summer month coverage. Any premiums stated in this benefit guide reflect a monthly premium (based on 12 months) and does not calculate the extra amount that will be deducted each month to collect premiums for the summer months of coverage. Premiums reflected as you go through enrollment through Employee Navigator will reflect the premium calculated based on either a 12-month or 9-month pay cycle depending on your employment category, but will not calculate any extra deductions that would be necessary if a mid-year election/change is applicable.

Medical Insurance

Sumner County Educational Services offers medical benefits through UnitedHealthcare. Three deductible plan options are available for you to choose the best option suited for you and your family. An online directory can be viewed at www.uhc.com; Choose the **CHOICE PLUS** plan when locating a provider.

> **The benefits illustrated below are in-network benefits**. There is coverage if you need to go out of the network. Out-of-network means that a provider does not have a contract with UHC. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

This is a brief summary of the coverage available under this program under **IN-NETWORK** providers. It is not a legal document. The exact provisions of the benefits and exclusions are contained in the certificate of coverage.

Deductible

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

- ⇒ Your co-pays don't count towards meeting the deductible
- ⇒ All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
- ⇒ **Deductible accumulate on a plan year (September 1—August 31)**

Deductible Plan Option	Option 1—$1,000 EFCX/538	Option 2—$3,500 EFDV/538	Option 3—$3,300 QHDHP EFEZ/O73
Health Savings Account Eligible	No	No	Yes
Medical Deductible—Individual	$1,000	$3,500	$3,300
Medical Deductible—Family	$2,000	$7,000	$6,600

Out-of-Pocket Limit

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amount over the amount UHC allows when you see an out-of-network provider.

- ⇒ All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.
- ⇒ Your co-pays, co-insurance and deductibles, including pharmacy, count towards meeting the out-of-pocket limit
- ⇒ **Out-of-pocket limits accumulate on a plan year (September 1—August 31)**

Deductible Plan Option	Option 1—$1,000	Option 2—$3,500	Option 3—$3,300 QHDHP
Out-of-Pocket Limit—Individual	$6,500	$7,000	$6,350
Out-of-Pocket Limit—Family	$13,000	$14,000	$12,700

ACA Preventive Care

Paid at 100% of the allowable charges—Certain preventive care services are provided as specified by the ACA, with no cost-sharing to you. These services are based on your age, gender an other health factors.

Physician's Office Services—Sickness and Injury

Primary Physician Office Visit			All Ages:
Covered person less than age 19	$0 copay	$0 copay	50% coinsurance
All other Covered persons	$0 copay	$20 copay	after deductible
Specialist Physician Office Visit			
All ages	$100 copay	$60 copay	50% coinsurance after deductible

UnitedHealthcare

Medical Insurance

Deductible Plan Option	Option 1—$1,000	Option 2—$3,500	Option 3—$3,300 QHDHP
Medical Services			
Lab, X-Ray and Diagnostics—Outpatient	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Urgent Care Center	$50 copay	$20 copay	50% coinsurance after deductible
Emergency Room Services	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Ambulance Services Prior authorization is required for non-emergency ambulance	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Physician Fees for Surgical and Medical Services	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Surgery—Outpatient	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Hospital—Inpatient	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Rehabilitation and Habilitative Services—Outpatient Therapy and Manipulative Treatment			
Rehabilitation Services and Manipulative Treatment—*Certain therapies are limited per year*	50% coinsurance after deductible	$20 copay	50% coinsurance after deductible
Mental Health Services			
Outpatient Office Visit	$0 copay	$60 copay	50% coinsurance after deductible
Inpatient	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Partial Hospitalization/Intensive Outpatient Treatment	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Virtual Care Services			
Network benefits are available only when services are delivered through a Designated Virtual Network provider for 24/7 virtual visit services only. You can find a 24/7 virtual visit provider by contacting UHC at myuhc.com or the telephone number on your ID card.			
Designated Virtual Provider	$0 copay	$0 copay	Subject to deductible

Deductible Plan Option	Option 1—$1,000	Option 2—$3,500	Option 3—$3,300 QHDHP
Outpatient Prescription Drug (Advantage Preferred Drug List)			
	Copay applies	Copay applies	Subject to deductible, then copay applies
Tier 1—Retail Copay | Mail Order* Copay	$10 | $30	$10 | $30	$20 | $60
Tier 2—Retail Copay | Mail Order* Copay	$50 | $150	$50 | $150	$50 | $150
Tier 3—Retail Copay | Mail Order* Copay	$100 | $300	$100 | $300	$100 | $300
Tier 4—Retail Copay | Mail Order* Copay	$250 | $750	$250 | $750	$200 | $600

* Only certain Prescription Drug products are available through mail order; please visit www.myuhc.com or call Customer Care on the back of your ID card.
For additional Prescript Drug Information see page 10 of the benefit guide and the Prescription Drug Benefit Summary posted online.

UHC Resources

UHC network health care providers, including doctors, specialists and hospitals, charge discounted rates, which typically saves you money. If your plan allows you to receive care outside of your health plan network, seeking care from an out-of-network provider could cost you more money.

For hospital care, talk with your doctor first to determine which hospital can meet your medical or surgical needs. You may be required to notify UnitedHealthcare before your hospital admission.

Locate A Medical Provider

1. Go to www.uhc.com
2. Click on **'Member Resources'** near the top of the page
3. Either sign in as a Member or Search as a guest
4. Next click on **'Medical Directory'**
5. Click on '**Employer and Individual Plans'** then '**Shopping Around'**
6. Select '**Choice Plus'** plan
7. Next, enter the location you want to find a provider in (zip code or city & state)
8. Select the type of provider you are searching for (People, Places, Tests and Imaging, Services & Treatment)
9. Continue selecting the parameters of your choice to find a designated network provider

Prescription Drug Information

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help manage your meds.

1. Go to welcometouhc.com > Pharmacy Benefits
2. Scroll down the page to the **Find your Medications** section
3. Select **Advantage 4-Tier PDL**
4. You will be redirected to the OptumRx website where you can search by drug name

- Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information.
- You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
- For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.
- An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket limit.

UHC Resources

Once you receive your ID card, register for myuhc.com and download the UnitedHealthcare Health4Me® mobile app

Use myuhc.com to find tools and information to help you manage your health and benefits.

- Find a doctor or facility that is part of your plan's network
- Find a network pharmacy and covered prescriptions
- Track claims and expenses for your family
- Plan ahead for tests and treatments
- Stay on top of your medical history
- Get tips to help improve your health

The UnitedHealthcare Health4Me Mobile App is available on the App Store and Google Play

UnitedHealthcare Member Benefits

UHC Rewards—Your health plan comes with a way to earn up to $300. With UHC Rewards, a variety of actions—including thing you may already be doing, like tracking your steps, getting an annual checkup, and more—lead to rewards.

Here are just a few ways you can earn:

Connect a tracker	$25
Take a health survey	$15
Get an annual checkup	$25
Get a biometric screening	$50

Once your insurance is effective, you can register/sign-in to your UHC member account to activate the UHC Rewards program and start earning. You can then use your earnings to redeem awards available through the UnitedHealthcare Rewards program.

Real Appeal® —UnitedHealthcare offers Real Appeal®, a voluntary online weight loss program available through Rally Coach™, to you and eligible family members at no additional cost as part of your health plan benefits (must be enrolled in the health plan). Get access to online coaching, tools to set goals and track your progress, and a community of support to help keep you motivated to reach your goals.

Quit for Life® has helped 3.5 million members quit smoking or using tobacco. It provides the tools and one-on-one support to help you quit your way. And for UnitedHealthcare members, it's offered at $0 out of pocket.

Calm Health App —The Calm Health app provides programs and tools to help support your mental health and well-being—all at your own pace. Learn techniques to improve well-being, work towards goals through self-guided self-care programs, access mental health information and support to help you strengthen the mind-body connection. As a UHC member, Calm Health is included in your health plan.

Once your insurance is effective, you can register/sign-in to your UHC member account to access all of the resources.

Dental Insurance

Sumner County Educational Services offers the following comprehensive dental plan administered by Delta Dental. Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your physical health.

The maximum Benefit for all covered services for each enrolled person in any one calendar year is $1,500.

Diagnostic & Preventive Services—You pay 0%

DIAGNOSTIC

Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:

- Oral evaluations—two (2) times per calendar year
- Bitewing x-rays—bitewings two (2) times per calendar year for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over
- Full mouth x-rays or panoramic x-rays—once each five (5) years

PREVENTIVE

Provides for the following:

- Prophylaxis (Cleanings) - unlimited
- Topical Fluoride—two (2) times per calendar year for dependent children under age nineteen (19)
- Sealants—once per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
- Space Maintainers—for dependent children under age fourteen (14) and only for premature loss of primary molars

Deductible applies to Basic and Major Services
Individual Deductible: $50 | Family Deductible Maximum: $150

Basic Services—You pay 50%

- Ancillary—Provides for one (1) emergency examination per calendar year by the Dentist for the relief of pain
- Oral Surgery—Provides for extractions and other oral surgery including pre and post-operative care
- Regular Restorative Dentistry—Provides amalgam (silver) restorations, composite (white) resin restorations on anterior (front) teeth only; and stainless steel crowns for dependents under age twelve (12)
- Endodontics—Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four(24) month period, per tooth
- Periodontics—Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis; Surgical periodontal procedures

Major Services—You pay 50%

- Special Restorative Dentistry—When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns
- Prosthodontics—Includes bridges, partial and complete dentures; repairs and adjustments of bridges and dentures

DELTA DENTAL®

Dental Insurance

Other Plan Benefits

Right Start 4 Kids Program—The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage, with no deductible, for all services covered under the plan when an in-network dentist (Delta Dental Premier or Delta Dental PPO) is seen. If an out-of-network dentist is seen, the underlying contract applies including deductibles and coinsurance levels.

Unlimited Cleanings: The plan will allow for unlimited cleanings. This includes regular/prophylaxis cleanings and periodontal maintenance cleaning.

Annual plan maximum applies.

You are free to go to any dentist of your choice; however, there may be a difference in the amount of payment if the dentist is not a Delta Dental participating dentist. Since nearly 4 out of 5 dentists nationwide contract with Delta Dental, the chances are excellent your dentist is already a member.

Why choose an in-network dentist?

- Discounts. Delta Dental network dentists agree to accept predetermined fees for services, which are usually discounted from typical charges. **Delta Dental PPO providers have a higher discount than Premier providers, which means your annual maximum benefit could go farther if using a PPO provider.** Delta Dental network dentists also agree not to bill patients for differences between the Delta Dental contracted fees and their typical charges.
- There's no waiting for reimbursement**.** When you are treated by a Delta Dental network dentist, you don't have to pay the entire bill and wait for reimbursement from Delta Dental. Instead, we pay your in-network dentist directly and send you a notice (Explanation of Benefits (EOB) statement) explaining your portion of the bill. You pay only the amount indicated in the statement.

Delta Dental Resources

Caring for smiles has been Delta Dental's focus for over 40 years. Educating members about of good oral health and giving back to the communities they serve drives the passion behind Delta Dental. Access Delta Dental's *Knowledge Center* as well as other valuable tools. Scan the QR code or visit www.deltadentalks.com to access information about your dental plan, including options to:

- Locate a participating Delta Dental Premier/PPO dentist anywhere in the United States
- Check your eligibility and plan information
- Print an ID card
- Check claim status
- Estimate your out-of-pocket dental care costs with the Flexible Spending Account Estimator
- Sign up to receive your Explanation of Benefits electronically
- Learn about oral health and wellness
- And More

Mobile App: Accessing information about your dental plan is easy and convenient through Delta Dental's mobile app. The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for "Delta Dental Mobile App".

Vision Insurance

Sumner County Educational Services offers a comprehensive vision plan through VSP to you and your eligible dependents. This plan gives you access to eye exams and materials benefits to you and your eligible dependents (children to age 26.)

Benefit	Description	Copay	Frequency
Your Coverage with a VSP In-Network Provider			
Well Vision Exam		**$10**	**Every plan year**
Prescription Glasses		**$25**	**See frame and lenses**
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every plan year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation	Up to $60	Every plan year
Primary EyeCare	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Vision Insurance

Using your VSP Benefits is Easy

- **Register at vsp.com**
  Once your plan is effective, review your benefit information

- **Find an eye care provider who's right for you.**
  To find a VSP provider, visit **vsp.com** or call **800.877.7195**

- **At your appointment, tell them you have VSP**. There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

You have access to **vsp.com** with easy navigation and a personalized dashboard to get exactly what you need, when you need it!

Quick view of your benefit information

Once logged in, My Dashboard is your homepage. You'll see personalized benefit information, including previous doctor visits, and more!

Intuitive benefits section

The My Benefits tab shows your benefits history and an explanation of how you and your dependents can use your benefits.

Download the app

The redesigned VSP® app is available for free in the Apple App store or Google Play store. Updated with a streamlined login process, easier navigation, and a personalized member dashboard to mirror the look and feel of your dashboard on **vsp.com**!

Improved find a doctor page

The search capabilities are endless on the Find a Doctor page! You can view a map and use the drop-pin functionality to find the right eye doctor for you in your region.

Create an account on VSP.com to get the most out of your benefits.

Your Coverage with Out-of-Network Providers—Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.
VSP guarantees coverage from VSP network 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.

Flexible Spending Accounts

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

Healthcare Flexible Spending Account: A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses. Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You can increase your spendable income by an average of 30% of your annual contribution with the tax savings.

Dependent Care Flexible Spending Account: A dependent care account (DCA) is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.

FSA Participation Considerations

Participating in the flexible spending plans to use pre-tax dollars for qualified out-of-pocket expense is a great benefit to reduce taxable income and manage and plan for expenses you know you will have. However, you do need to plan appropriately so that you can be reimbursed with the money that is deducted from your paycheck.

- You do not have to be enrolled in any other plans (i.e. medical, dental, vision, etc.) to participate in the FSA plans.
- You can enroll in one or both accounts. Each account is a separate election.
- Over-the-counter drugs and medications and menstrual care products are considered eligible expenses under the Healthcare FSA.
- Plan carefully when deciding how much you want to contribute to your account(s) for the year. The elections you make will remain in effect until the end of the plan year and cannot be changed for any reason unless you experience a qualified event, become and ineligible participant or termination of employment.
- The rules and regulations of the IRS govern all FSA accounts.
- FSA Plan participants (for terminated or ineligible participants) may incur claim expenses up to the date of termination/ineligibility and have 30-days from date of termination to file claims.
- Plan members will receive a **HealthEquity FSA Debit Card** which can be used instead of cash at providers and wherever accepted for health-related services and expenses.

HealthEquity FSA Administration

- Mobile-optimized account management, with easy claims and reimbursement (Account must be activated via the HealthEquity website in order to use the mobile app.)
- Step-by-step on-screen tutorials in the member dashboard
- Help Center with comprehensive user guides and hot-to articles
- 24/7 call or chat with HealthEquity's 100% US-based Member Services Team

(866) 735-8195 | HealthEquity.com/learn

FSA Administrator

HealthEquity

Flexible Spending Accounts

	Health Care FSA	Dependent Care FSA (DCA)
Maximum Annual Election	**$3,300** Your annual election will be divided over the number of pay periods in your plan year.	**$5,000** *($2,500 if married filing separately)* Your annual election will be divided over the number of pay periods in your plan year.
Plan Year	**September 1, 2025—August 31, 2026** Expensed must be incurred during the plan year. Expenses are incurred at the time the service was provided, not when you are invoiced or pay the bill.	
How soon can you start spending your FSA funds?	With a healthcare FSA, your entire annual election amount is available on the first day of the plan year.	You will have access to your Dependent Care FSA funds that have been deducted from your paycheck.
What expenses are eligible for reimbursement?	Health plan co-pays, deductibles, co-insurance, vision care, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502)	You can use your DCA to pay for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support). Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school , summer day camp, or a nanny in your home.
How do you use the funds in your account?	If you have a benefits debit card, simply swipe it at the register. Otherwise, just file a claim including the receipt documenting the type, amount and date. Once approved, your reimbursement check will be mailed or deposited into your bank account.	Pay out-of-pocket and then file a reimbursement claim with your expense documentation.
Can you change your election amount mid-plan year?	Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.	Typically, you cannot change your contribution mid-year. However, if you experience a qualifying event, such as the birth of a new child, or if your child care provider significantly increases their rates, you may be eligible to adjust your contribution.
What happens if you don't spend all of your FSA funds by the end of the plan year?	If any balance remains in the Participant's Health FSA Account after the claim filing period, then any such balance up to $660 shall be carried over to reimburse the Participant for Health Care Expenses incurred during the subsequent Plan Year, provided that the Participant has not exercised his or her right to waive any right to any such carryover and provided that the Employer does not require an election for the subsequent Plan Year. Notwithstanding the foregoing, the Participant shall forfeit all rights with respect to any such balance above $660.	It is essential to estimate conservatively during elections. Any unused funds at the end of the plan year are forfeited, also called the use-it-or-lose-it rule.
What happens if I become an ineligible participant during the plan year?	If you terminate employment or no longer meet the plan eligibility requirements, your participation in the Health Care FSA and/or Dependent Care FSA plan will end. FSA Plan participants (for terminated or ineligible participants) may incur claim expenses up to the date of termination/ ineligibility.	

REMINDER: Always request a detailed receipt from the provider, even when using the FSA Debit Cart. The IRS requires you to keep them for your tax records; and you will also need them if your FSA vendor requests substantiation of qualified expenses.

Short-term Disability

Sumner County Educational Services provides benefit eligible employees with the opportunity purchase disability income protection through Mutual of Omaha. In the even you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income. Disability insurance replaces a portion of your income if an injury or illness forces you out of work for a period of time.

Eligibility	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 25 hours per week to be eligible for coverage.
Coverage Payment	You pay 100% of the premium for this coverage through easy payroll deduction.
Benefits	
Benefits Begin (Elimination Period) If you become disabled, there is an elimination period before benefits are payable.	Your benefits begin: On the 15th day of your disabling injury On the 15th day of your disabling illness
Weekly Benefit	Your benefit is equivalent to 66 2/3% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount.
Maximum Benefit Period	Short-term disability benefits are available for up to 24 weeks . Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.
Maximum Weekly Benefit	$1,500
Minimum Weekly Benefit	$15
Features	
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a weekly benefit increase of 5%.

Note: This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail.

EXCLUSIONS & LIMITATIONS	
Pre-existing Conditions Limitation	Disabilities that occur during the first 6 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
Other Exclusions	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

Definition of Disability: Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.

Definition of Weekly Earnings: Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.

Mutual of Omaha

Short-term Disability

Why Is Disability Insurance So Important?

The risk of disability is greater than most employees realize. When you become disabled and lose time at work, your source of income is eliminated. Nearly one-third of employees will miss more than one month of pay due to injury or illness. In addition to lost income, you are most likely experiencing an increase in medical expenses due to your disabling injury or illness.

What is Supplemental (Voluntary) Disability Insurance?

Traditional medical insurance doesn't cover every expense related to an injury or illness. Bills and expenses can continue to add up, especially if you have to stop working for a period of time and lose your income. Supplemental insurance is additional coverage that can help you pay deductibles or copayments and other increasing medical costs not covered by your employer-sponsored insurance plan.

Value Added Benefit—Hearing Discount Program

The Hearting Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call (888) 534-1747 or visit amplifonusa.com/mutualofomaha to learn more.

Monthly Premium Calculation		Example (42-year old employee earing $40,000 a year)
List your weekly earnings (Maximum is $2,249.89)	$_____	$ 769.23
Multiply by the premium factor	0.0413354	0.0413354
Your Estimated Monthly Premium **	$_____	$ 31.80

** Your monthly premium will be calculated when you elect your benefits through the Employee Navigator enrollment system. This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Life Insurance

Sumner County Educational Services provides eligible employees the opportunity to purchase Voluntary Life Insurance on yourself, spouse and dependent children. You pay the total cost of this benefit through convenient payroll deductions. This benefit is offered through Mutual of Omaha—portability/conversions options are available if your employment ends. Below is a brief summary of coverage options. Keep your beneficiaries updated in the Employee Navigator benefit system.

Coverage Options

Employee Option

- $10,000 to $500,000, not to exceed 5x annual salary, whichever is less
- Purchased in increments of $10,000
- Guarantee issue[1] at initial opportunity is $100,000, not to exceed 5x annual salary
- Includes matching Accidental Death & Dismemberment benefit
- Life and AD&D age reductions apply[2]
- Accelerated death benefit available if diagnosed with a terminal condition

Spouse Option

- $5,000 to $50,000, not to exceed 100% of employee election
- Purchased in increments of $5,000
- Guarantee issue at initial opportunity is $25,000, not to exceed 100% of employee election
- Includes matching Accidental Death & Dismemberment benefit

Child(ren) Option

- Flat $10,000 benefit
- Child(ren) covered up to age 26
- Includes matching Accidental Death & Dismemberment benefit
- One premium covers all eligible children
- No EOI required (even as a late enrollee)

Spouse and Dependent Child(ren) coverage can only be taken in conjunction with Employee Coverage. To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility) - applicable to all amounts, including guarantee issue amounts. A spouse or child who is insured as an Employee under this plan cannot also be insured as a dependent. If both you and your spouse are insured under this plan as employees, only one of you may insure your child(ren) as dependents.

[1]Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

[2]Under this plan insurance benefits and guarantee issue amounts are subject to age reductions. your coverage amount reduces by your age as follows: by 35% at age 70, by 55% at age 75, and by 70% at age 80,by 80% at age 85 and by 85% at age 90. Your spouse's coverage terminates when you reach age 70

Annual Increase Option—Employee Coverage Only

If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).

Life Insurance

Voluntary Term Life and AD&D Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding. **To select your benefit amount and calculate your premium, do the following:**

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

2) Find your age bracket in the far left column.

3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.

4) If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

The benefit amounts and associated premium you are eligible for will be displayed as you make your elections through the

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.80	$1.60	$2.40	$3.20	$4.00	$4.80	$5.60	$6.40	$7.20	$8.00
30 - 34	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$8.30	$7.20	$8.10	$9.00
35 - 39	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
40 - 44	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00
45 - 49	$2.40	$4.80	$7.20	$9.60	$12.00	$14.40	$16.80	$19.20	$21.60	$24.00
50 - 54	$3.80	$7.60	$11.40	$15.20	$19.00	$22.80	$26.60	$30.40	$34.20	$38.00
55 - 59	$5.90	$11.80	$17.70	$23.60	$29.50	$35.40	$41.30	$47.20	$53.10	$59.00
60 - 64	$9.00	$18.00	$27.00	$36.00	$45.00	$54.00	$63.00	$72.00	$81.00	$90.00
65 - 69	$16.00	$32.00	$48.00	$64.00	$80.00	$96.00	$112.00	$128.00	$144.00	$160.00
70 - 74	$28.50	$57.00	$85.50	$114.00	$142.50	$171.00	$199.50	$228.00	$256.50	$285.00
75 - 79	$46.80	$93.60	$140.40	$187.20	$234.00	$280.80	$327.60	$374.40	$421.20	$468.00
80+	$94.50	$189.00	$283.50	$378.00	$472.50	$567.00	$661.50	$756.00	$850.50	$945.00

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child (ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00
30 - 34	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
35 - 39	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
40 - 44	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50
45 - 49	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
50 - 54	$1.90	$3.80	$5.70	$7.60	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00
55 - 59	$2.95	$5.90	$8.85	$11.80	$14.75	$17.70	$20.65	$23.60	$26.55	$29.50
60 - 64	$4.50	$9.00	$13.50	$18.00	$22.50	$27.00	$31.50	$36.00	$40.50	$45.00
65 - 69	$8.00	$16.00	$24.00	$32.00	$40.00	$48.00	$56.00	$64.00	$72.00	$80.00

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*

$10,000
$2.40

*One premium covers all eligible children

Additional Information for Employee/Spouse Coverage:

- Rates will increase as you age and move to the next age band.

Mutual of Omaha

Supplemental Insurance

Important Notice: This Policy is an accident insurance policy. It does not pay benefits for losses caused by sickness. Coverage under this Policy is not comprehensive medical coverage and is not intended to cover the cost of all hospital or other medical services. The Policy does not satisfy the minimum essential coverage requirements of the Affordable Care Act.

Sumner County Educational Services allows Aflac to offer benefits to benefit eligible employees and will payroll deduct premiums and remit payment to Aflac. Benefits payable under any of the Aflac coverages are paid directly to you and do not coordinate with any other insurance.

If you have any questions regarding the benefit coverages available through Aflac please contact the Aflac representative. Additional benefits may be offered that are not listed below.

Cancer/Specified-Disease Pan

The Cancer/Specified-Disease plan helps with medical expenses related to cancer and other specified-disease treatment. The policy pays a benefit for such things as:

- Initial Diagnosis Benefit
- Hospital Confinement Benefit
- Radiation and Chemotherapy Benefit
- Surgical/Anesthesia Benefit
- Ambulance Benefit
- Transportation Benefit
- Lodging Benefit
- Cancer Wellness Benefit

Critical Care and Recovery Plan

The Critical Care and Recovery Policy helps with the medical expenses related to covered serious health events. This policy pays a first-occurrence benefit, as well as Hospital Confinement and Continuing Care benefits for:

- Heart Attack
- Stroke
- Sudden Cardiac Arrest
- Coronary Artery Bypass Surgery
- End-State Renal Failure
- Major Human Organ Transplant
- Major Third-Degree Burns
- Coma
- Paralysis

Accident Plan

The Accident Plan helps provide a financial cushion if an accident occurs. The policy pays a benefit for such things as:

- Emergency Treatment Benefit
- Specific-sum Injuries Benefit
- Accidental Death Benefit
- Initial Hospitalization Benefit
- Hospital Confinement Benefit
- And More...

Hospital Intensive Care Plan

The Hospital Intensive Care Plan helps cover expenses related to confinement in an intensive care unit (ICU). The policy pays a benefit for:

- Daily Hospital ICU Confinement Benefit
- Daily Step-down ICU Confinement Benefit
- Ambulance Benefit
- Major Human Organ Transplant Benefit

For More Information Contact:
Aflac Agent | Trudy Kamphaus
(620) 229-3289 | trudy_kamphaus@us.aflac.com

Legal Notices

CONTINUATION OF HEALTH PLAN COVERAGE

A federal law, commonly referred to as COBRA (for Consolidated Omnibus Budget Reconciliation Act) gives you and your covered dependents the right to continue health plan coverage in certain circumstances when it would otherwise end. These include termination of employment or reduction in hours causing loss of plan eligibility of the covered employee, as well as for covered dependents, the death of the covered employee, a divorce or legal separation from the covered employee, or ceasing to be an eligible dependent child of the employee.

IT IS VERY IMPORTANT THAT YOU NOTIFY PERSONNEL SERVICES IF YOU EXPERIENCE A DIVORCE/LEGAL SEPARATION OR HAVE A DEPENDENT WHO NO LONGER MEETS THE ELIGIBILITY RULES OF THE PLAN.

If you do not notify the Benefits Office of one of these events within 60 days, your covered dependents will lose the right to continue their coverage under COBRA. More details are available in the COBRA notification material sent to new health plan participants.

NOTICE OF SPECIAL ENROLLMENT PROVISIONS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after you or your dependents lose eligibility for that other coverage (or employer contributions toward that coverage end). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment, contact the Benefits Office.

HIPAA PRIVACY

The Company Flexible Spending Account Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by USD 475 is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through Personnel Services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided, subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

SPECIAL RULES FOR MOTHERS AND NEWBORNS

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

NOTICE OF CHIPRA POLICY

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. Contact your State for more information on eligibility –

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

This is a partial listing of states with Medicaid or CHIP programs, and that a copy of the complete notice is available from the employer. For additional state information or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.
Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

(*continued* Health Insurance Marketplace Coverage Options and Your Health Coverage)

In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Employer as listed below.

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

(*continued* Health Insurance Marketplace Coverage Options and Your Health Coverage)

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: **Sumner County Educational Services 619**
Employer EIN: **48-0935785**
Employer Address: **2612 N. A Street | Wellington, KS 67152**
Employer Phone #: **(620) 326-8935**
Contact Person: **Sumner County Interlocal Office**

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

- Certified employees who are contracted for at least 30-hours per week; Classified employees who are regularly scheduled to work at least 30-hour per week

- Eligible dependents are: Legal Spouse and Children to age 26, including step, adopted and foster children, and any child you have legal guardianship or court-ordered custody. A child who is incapable of self-support due to handicap resulting from a physical condition or mental illness may be approved over the allowed age limit of 26.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. The above information is the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sumner County Educational Services Interlocal 619 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. Blue Cross Blue Shield of Kansas has determined that the prescription drug coverage offered by Sumner County Educational Services 619 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Sumner County Educational Services Interlocal 619 coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Sumner County Educational Services Interlocal 619 coverage, be aware that you and your dependents will be able to get this coverage back.

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 Sumner County Educational Services Interlocal 619 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.

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).

Name of Entity/Sender: Sumner County Educational Services Interlocal 619
Contact--Position/Office: Sumner County Interlocal Office
Address: 2612 N. A Street | Wellington, KS 67152
Phone Number: (620) 326-8935
Print Date: August 2025

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).

Contact Information

Interlocal 619
SUMNER COUNTY EDUCATIONAL SERVICES

Benefit Office
Dara Smythe
dsmythe@d619.org
(620) 326-8935

Brown & Brown

Benefit Consultants
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(316) 448-5114

Ruth Shank
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Carrier	Carrier Contact
UnitedHealthcare Medical & Prescription Drug Coverage	www.uhc.com Member Service..... (866) 633-2446
Delta Dental of Kansas Dental Coverage	www.deltadentalks.com Customer Service..... (800) 234-3375
VSP Vision Coverage	www.vsp.com Customer Service..... (800) 877-7195
HealthEquity Flexible Spending Account	www.healthequity.com Customer Service..... (866) 735-8195
Mutual of Omaha Life Insurance Disability Insurance	www.mutualofomaha.com Customer Service..... (800) 369-3809
Aflac Worksite Benefits	Agent—Trudy Kamphaus www.aflac.com Agent..... (620) 229-3289 Email .....trudy_kamphaus@us.aflac.com

Sumner County Educational Services Interlocal 619

2612 N. A Street | Wellington, KS 67152
(620) 326-8935

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

Brown & Brown Insurance Services,, Inc.
(316) 448-5201 | BBrown.com