Summary of Fringe Benefits for Certified Staff

HEALTH & VISION INSURANCE

Single $9,400/Multi-Person $13,300/Family $16,300/Dual Employee $18,500 benefit per year provided by the Corporation

2022 SEMI-MONTHLY PREMIUMS-(AMOUNT PAID BY EMPLOYEE)

Anthem Health & VSP Vision

	Plan 5	Plan 6
Single	$96.00	$0.01
Member/Spouse	$385.00	$121.00
Member/Child(ren)	$426.00	$137.00
Family	$471.00	$148.00

*If you choose **not** to enroll in a medical plan, if you qualify, the Corporation will provide a Short Term Disability plan for you. It will be your responsibility to enroll with American Fidelity during the fall enrollment period.*

DENTAL INSURANCE

Dental insurance is offered with no contribution made by the corporation

SEMI-MONTHLY PREMIUMS
(AMOUNT PAID BY EMPLOYEE)

Paramount Dental (HRI)

Single	$15.12
Employee + 1 Dependent	$31.12
Employee + Family	$51.12

LIFE INSURANCE

WCSC provides a basic term life insurance policy in the amount of $50,000 for $.01 per year. Additional life coverage may be purchased at the following rate:

Symetra Life Insurance

Additional life insurance may be purchased in $10,000 increments for an additional $2.70 (for each $10,000 added) up to $250,000

Dependent Life:

$2.25	$10,000 - Spouse, $5,000 each child
$5.25	$25,000 - Spouse, $10,000 each child

LONG-TERM DISABILITY

Long Term Disability is paid by the Corporation.

INDIANA STATE TEACHERS RETIREMENT FUND

In addition to the state mandated contribution percentage to the employee's pension plan, WCSC also contributes the required 3 percent to the employee's defined contribution account.

SICK LEAVE BANK

Each new employee will be asked to voluntarily donate (1) day of their accumulated sick leave to the Sick Leave Bank. This contribution will entitle them to withdrawal benefits described in the Sick Leave Bank. Employees will be asked to give another day when/if the sick leave bank falls below 100 days.

Sick Days
10 days per school year

Personal Days
5 days per school year

Bereavement Days
Per Contract

WCSC
HEALTH INSURANCE

WARRICK COUNTY SCHOOL CORPORATION

2022 Health Insurance Renewal

Great year for Health Insurance Renewal!!

The following is a summary of the plan design costs available for 2022. Use this information to select your health plan from among the two (2) options. Plan #'s 5 and 6 are exactly the same as 2021. Pay special attention to the column labeled "2022 Semi-Monthly Employee Contribution." This is the amount that is deducted from your paycheck 24 times from December 2021 through November 2022 (2 of 26 paychecks do not have deductions).

Anthem Blue Access PPO BA H.S.A. Option E1 RX T8 ($3,000 Deductible)

	Established Monthly Premium	Months	Yrly Premium	Employer Cont.	Employee Due	Monthly Employee Contribution	2021 Semi-Monthly Employee Contribution (Dec-Feb)	2021 Semi-Monthly Employee Contribution (Mar-Nov))	2022 Semi-Monthly Employee Contribution (Dec-Nov)	2021 Semi-Monthly Employee Contribution Dual-Members (Dec-Feb)	2021 Semi-Monthly Employee Contribution Dual-Members (Mar-Nov)	2022 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$976	12	$11,712	$9,400	$2,312	$193	$126	$96	$96	NA	NA	NA
Emp/Sp	$1,878	12	$22,536	$13,300	$9,236	$770	$416	$386	$385	$214	$178	$168
Emp/Child	$1,960	12	$23,520	$13,300	$10,220	$852	$457	$427	$426	NA	NA	NA
Family	$2,300	12	$27,600	$16,300	$11,300	$942	$504	$474	$471	$425	$382	$379

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	2021 Semi-Monthly Employee Contribution (Mar-Nov))	2022 Semi-Monthly Employee Contribution (Dec-Nov)	2021 Semi-Monthly Employee Contribution Dual-Members (Dec-Feb)	2021 Semi-Monthly Employee Contribution Dual-Members (Mar-Nov)	2022 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$783	12	$9,400	$9,400	$0	$0	$26	$0.01	$0	NA	NA	NA
Emp/Sp	$1,350	12	$16,200	$13,300	$2,900	$242	$154	$124	$121	$0	$0	$0
Emp/Child	$1,382	12	$16,584	$13,300	$3,284	$274	$169	$139	$137	NA	NA	NA
Family	$1,653	12	$19,836	$16,300	$3,536	$295	$183	$153	$148	$102	$62	$56

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 $18,500 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 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. E1	$96.00	24	$2,304.00		$3,000.00	$5,304.00	Pay 0% after deductible	$0.00	$5,304.00	1000	$6,304.00	
H.S.A. E4	$0.01	24	$0.24		$5,000.00	$5,000.24	Pay 0% after deductible	$0.00	$5,000.24	950	$5,950.24	*

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. E1	$471.00	24	$11,304.00		$6,000.00	$17,304.00	Pay 0% after deductible	$0.00	$17,304.00	2000	$19,304.00	
H.S.A. E4	$148.00	24	$3,552.00		$10,000.00	$13,552.00	Pay 0% after deductible	$0.00	$13,552.00	1900	$15,452.00	*

*** 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.

DEACONESS CLINIC AT WORK

Is Excited to Work with You!

In your program, you'll find the following benefits available to you and your dependents:

- **Free Provider Visits**—Sick visits, annual exams, sports/wellness physicals, chronic disease management, basic in-office procedures, stitches, EKGs, lung function tests.
- **Free Medications**
- **Free Labs**
- **Free DC LIVE Telehealth Visits**—8:00 AM – 8:00 PM, 365 days a year (age 2 and older)
- **Free 24-Hour Nurse Line**

Visit your company's Deaconess Clinic at Work webpage for access to:

- Appointment Scheduling
- Medication Refills
- DC LIVE
- And More!

LOCATIONS

Newburgh — 812-450-7888 Opt. 1
3711 Casey Road, Newburgh, IN
Monday: 7 AM–5 PM
Wednesday: 11 AM–6 PM
Thursday: 7 AM–4 PM

Boonville — 812-450-7888 Opt. 2
930 W. Main Street, Boonville, IN
Tuesday: 7 AM–5 PM
Friday: 7 AM–4 PM

dh Deaconess Clinic AT WORK

M3520 (11-2021) mh

WCSC
$3,000 DEDUCTIBLE ANTHEM PLAN #5

Your summary of benefits

WCSC - Plan #5

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

IPST – Warrick County School Corp

Effective: 01/01/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$12,000 person / $24,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device*	Not covered	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 15 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	0% coinsurance 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 a Non-Network Provider
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance 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 a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy is limited to 20 visits per benefit period. Occupational therapy is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	0% coinsurance 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 a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance 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.*	0% coinsurance 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 a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail)	50% coinsurance, min $60 after deductible is

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
	and $10 copay per prescription after deductible is met (home delivery)	met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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) *Per 30 day supply (specialty pharmacy).*	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)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-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 a Non-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.

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.

Your Plan: Anthem Blue Access PPO HSA Option E1 with Rx Option T8

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.

WCSC
$5,000 DEDUCTIBLE
ANTHEM
PLAN #6

Your summary of benefits

WCSC Plan #6

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

IPST – Warrick County School Corp

Effective: 01/01/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 person / $10,000 family	$10,000 person / $20,000 family
Out-of-Pocket Limit	$5,950 person / $11,900 family	$20,000 person / $40,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device*	Not covered	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	0% coinsurance 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 a Non-Network Provider
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance 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 a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy is limited to 20 visits per benefit period. Occupational therapy is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	0% coinsurance 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 a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance 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.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance 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.*	0% coinsurance 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 a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Rx Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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) *Per 30 day supply (specialty pharmacy).*	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)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-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 a Non-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.

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.

Your Plan: Anthem Blue Access PPO HSA Option E4 with Rx Option T8

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.

VISION INSURANCE
VSP

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM WARRICK COUNTY SCHOOL CORPORATION AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

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 for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 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®—a comprehensive exam designed to detect eye and health conditions.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

01/01/2022

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Every calendar year	$5
PRESCRIPTION GLASSES		$10
FRAME	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • Every other calendar year	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
DIABETIC EYECARE PLUS PROGRAM℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20 per exam
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine 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	
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.

Contact us:

800.877.7195 or **vsp.com**

Classification: Restricted

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 Boonville, IN 47601			
Group no.	Sub-group no.			Employee no./Dept. name
00228586				

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			
	☐ 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 $3000 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			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_____

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	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes,attach legal documentation)	

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	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

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 name _____ Social security no._____

SECTION 12: 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 an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, 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 provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional 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 assistance program).

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

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

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

Employee signature X	Date

HEALTH SAVINGS ACCOUNT INFORMATION

The HSA Authority
OLD NATIONAL BANK

2022

EDUCATION & ENROLLMENT PACKET

A health savings account (HSA) is a tax-advantaged checking account that gives you the ability to save for future medical expenses or pay current ones. It is individually owned; however, you may elect to designate an authorized signer who may also withdraw funds and be issued a debit card.

HSA Eligibility

To be eligible to make deposits to an HSA, the account holder:

- Must be currently enrolled in an HSA-qualified health plan
- May not be enrolled in any other non-HSA qualified health plan
- May not have, or be eligible to use, a general purpose flexible spending account (FSA)
- Cannot be claimed as a dependent on another person's tax return
- May not be enrolled in Medicare, Medicaid or Tricare
- Must not have used VA medical benefits in the past three months, with the exception of preventative services or treatment for a service-connected disability

Contributions to your HSA

The annual maximum allowable contributions to an HSA, as established by the IRS, for 2022 are **$3,650: Individual** and **$7,300: Family**.

Individuals 55 and older can make an additional catch-up contribution of $1,000 in 2022. A married couple can make two catch-up contributions if both spouses are eligible. The spouses must deposit the catch-up contributions into separate accounts.

The annual maximum contribution is based on a calendar year and there is no limit to the dollar balance that can build in the account over time. Contributions can come from:

- Employee pre-tax payroll withholding
- Employer contributions (non-taxable income)
- Individual contributions from account owner or other individual (tax-deductible for account holder)
- IRA or Roth IRA rollover

Distributions from your HSA

- You, or an authorized signer, can make withdrawals (or distributions) for qualified expenses.
- Distributions from your HSA can be made by check, debit card, ATM, online transfer or bill payment or by in-person request.
- Distributions for qualified medical expenses are tax free.
- Distributions made for anything other than qualified medical expenses are subject to IRS tax plus a 20% penalty. The penalty is waived if the account owner is 65 or older, or due to death or disability.
- Qualified medical expenses for your spouse and your tax dependents may be paid from your HSA, even if those individuals are not covered under your high-deductible health plan (HDHP).
- You're responsible for keeping receipts for all distributions from your HSA. The bank does not monitor how the funds are spent.

ADVANTAGES OF AN HSA

Portability | Keep 100% of the deposited funds with you when you retire or change employers. You are the account owner.

Flexibility | You can choose whether to spend the money on current medical expenses, or you can save your money for future use. Unused funds remain in the account from year to year and there is no "use it or lose it" provision.

Tax Savings | Contributions are tax free (pre-tax through payroll deductions or tax deductible). Earnings are tax free. Funds withdrawn for eligible medical expenses are tax free.

Premium Savings | An HSA-qualified insurance plan tends to be less expensive than a traditional insurance plan.

Allowable Expenses

To be a qualified medical expense, the expense has to be primarily for the diagnosis, cure, mitigation, treatment or prevention of disease. It must be to alleviate or prevent a physical or mental defect or illness. These expenses may or may not apply to your insurance deductible depending on the coverage provided by your medical plan.

Vision and dental expenses, such as glasses, contact lenses, eye exams, dental cleanings and orthodontia are all allowable expenses from your HSA. Medical supplies and over-the-counter medications such as Band-Aids, crutches, test strips, aspirin, allergy medicines and even contact solution are allowable.

Insurance premiums are allowable *only under the following circumstances*: while receiving federal or state unemployment benefits, COBRA premiums, qualified long-term care insurance premiums and Medicare and other health care premiums after age 65 (with the exception of Medicare supplement policies such as Medigap).

EXAMPLES OF ALLOWABLE EXPENSES (RECENT CHANGES IN BOLD):

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Bandages
- Birth Control Pills
- Breast Reconstruction
- Car Hand Controls (for disability)
- Chiropractors
- Christian Science Practitioners
- Contact Lenses
- Crutches
- Dental Treatment
- Dermatologist
- Diagnostic Devices
- Disabled Dependent Care Expenses
- Drug Addiction Treatment (inpatient)
- Eyeglasses
- Fertility Enhancement
- Guide Dog
- Gynecologist
- Hearing Aids
- Home Care
- Hospital Services
- Laboratory Fees
- LASIK Surgery
- Lodging (for out-patient treatment)
- Long-Term Care
- Meals (associated with receiving treatments)
- Medicare Deductibles
- **Menstrual and Feminine Hygiene Products**[1]
- Nursing Care
- Nursing Homes
- Obstetrician
- Operations
- Ophthalmologist
- Optician
- Optometrist
- Organ Transplant (including donor's expenses)
- Orthodontia
- Orthopedist
- **Over-the-Counter Medications**[1]
- Oxygen and Equipment
- Pediatrician
- Personal Care Services (chronically ill)
- Podiatrist
- **PPE: Masks, Hand Sanitizer and Sanitizing Wipes**[2]
- Prenatal Care
- Prescription Drugs
- Prescription Medicines
- Prosthesis
- Psychiatric Care
- Qualified Long-Term Care Services
- Smoking Cessation Programs
- Surgeon/Surgical Room Costs
- Therapy
- Transportation Expenses for Health Care Treatment
- Vaccines
- Vitamins (if prescribed)
- Weight Loss Programs (certain expenses if diagnosed by physician)
- Wheelchair
- Wig (for hair loss from disease)
- X-Rays

Non-Allowable Expenses

Insurance premiums are not eligible expenses (exceptions listed above).

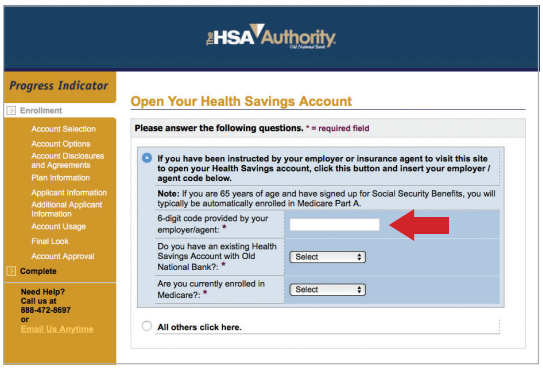
Costs associated with non-medically necessary treatments are not eligible. This includes cosmetic surgery and items meant to improve one's general health (but which are not due to a specific injury, illness or disease) such as health club dues, gym memberships, vitamins and nutritional supplements.

EXAMPLES OF NON-ALLOWABLE EXPENSES:

- Advance Payment for Future Medical Expenses
- Automobile Insurance Premium
- Baby-sitting (healthy children)
- Commuting Expenses for the Disabled
- Controlled Substances
- Cosmetics and Hygiene Products
- Diaper Service
- Domestic Help
- Electrolysis (hair removal)
- Funeral Expenses
- Hair Transplant
- Health Club/Gym Memberships
- Household Help
- Illegal Operations and Treatments
- Illegally Procured Drugs
- Maternity Clothes
- Nutritional Supplements
- Premiums for Accident Insurance
- Premiums for HSA Qualified Health Plan (prior to age 65)
- Premiums for Life or Disability Insurance
- Scientology Counseling
- Teeth Whitening
- Travel for General Health Improvement
- Tuition in a Particular School for Problem

[1]Per CARES ACT—No prescription needed. Effective 1/1/20.
[2]For the primary purpose of preventing the spread of COVID-19. Effective 1/1/20.

OPENING YOUR HSA ONLINE



If you already have an open HSA with The HSA Authority at Old National Bank, you do not need to complete the account opening process again.

Required Information

- Unexpired government-issued ID for account holder and authorized signer, if elected. This can be a driver's license, state-issued ID, passport or military ID.
- Date of birth for your beneficiaries.
- Social security number and date of birth for authorized signer, if elected.

How to Open Your Account

1. Go to **theHSAauthority.com**. Click **Open an HSA**.
2. The internet browser notice will appear. Click **Proceed to Application**.
3. Select the option **If you have been instructed by your employer...** When prompted, enter your six-digit employer code listed below. If you are not with an employer group, select **All others click here.**
4. Click **Continue** and complete enrollment. Submit the application and you'll receive a confirmation number.
5. A welcome letter will arrive in the mail within 10 business days of your application and should be retained for your records.
6. If you requested a debit card, it will be mailed separately. If checks are requested, the order is held and processed after your balance reaches $25.00.

Online Banking & eStatements

Your welcome letter contains your new HSA number along with instructions for accessing the Old National Bank online banking site and telephone banking system. To avoid the paper statement fee, be sure to follow the instructions in the welcome letter to elect eStatements. If you'd like assistance using these services, please call our Client Care Center toll-free at 888-472-8697.

EMPLOYER NAME

Warrick County School Corporation

EMPLOYER CODE

160368

The HSA Authority
OLD NATIONAL BANK

WEBSITE FEATURES

Visit theHSAauthority.com for helpful tools and information.

Tools

Under **Resources/Tools**, find:

- **HSA Videos & Articles** to address specific aspects of owning and managing your HSA.
- **Investment Tutorials** to demonstrate how to navigate the HSA Investment website.
- **Calculators** to allow comparison between a high-deductible plan with an HSA to a traditional plan and calculate the future value of an HSA.
- **Digital Services** to access, manage and use your HSA when convenient for you.

Client Library

Under **Resources/Client Library**, find:

- **Forms** for making changes to your account, such as: Address Change Form, Additional Authorized Signer Form, Beneficiary Change Form, Name Change Form, HSA Transfer Form and more. Many update requests can be submitted electronically through online banking.
- **Documents** such as informational flyers including HSAs and Medicare, HSAs and Retirement and many others.

Savings

Under **Resources/Savings**, find:

- **The HSA Store**, a resource to help you save on the purchase of products covered by your HSA funds.
- **HSA Store Eligibility** to ensure your purchase complies with IRS regulations.

HSA to HSA Transfers

If you have an HSA balance at another institution you would like to transfer:

- Open your HSA Checking account first and wait until you receive the welcome letter in the mail with your new account number.
- Complete and submit our HSA Transfer Form—located in the **Client Library** on our website.

HSA Investments

Visit our website at **theHSAauthority.com**.

Find **Individual/Employee Products** then click on **Investment Services** from the navigation menu. Information includes an Investment Options List, FAQs and Enrollment Form. HSA Checking must be opened first before enrolling in HSA Investments.

Features:

- A variety of mutual funds available from which to choose
- Easy to use and comprehensive investment website
- Annual fee of $36
- No investment load or trade costs (*Short term redemption fee may apply to some funds if selected)*

IMPORTANT INFORMATION: Self-directed investments are the sole responsibility of the account-owner. Carefully weigh the advantages and disadvantages of investing your HSA funds before doing so. Investment products are not FDIC insured; may lose value and are not a deposit account. Investment accounts are not obligations of Old National Bank or Devenir, are not guaranteed, and not insured by any federal government agency.

HSAs at Tax Time

- You'll receive **Form 1099 SA** for your distribution total and **Form 5498 SA** for your contribution total for the previous year. These figures are reported to the IRS and you are required to report them on **IRS Form 8889** when filing your federal taxes. See IRS Publication 969 or consult your tax advisor for further information.
- You may make contributions to your HSA for the previous calendar year up to the tax filing deadline, which is normally April 15. If you make prior year deposits, you will receive an **updated Form 5498 SA** in May with your complete contribution total to keep with your tax records.

Prior Year Deposits: Prior year contributions should be clearly communicated to bank personnel. If mailing a deposit, be sure to note it is for the prior year. Deposits made at an ATM machine, remote deposit using a mobile phone, electronic transfers made using any method or those that are not specifically communicated to bank personnel will automatically be processed as a current year contribution.

Insurance Coverage Changes

- If you start an HSA-qualified health plan mid-year, you may contribute the full annual maximum to your HSA. However, a testing rule applies to those that start an HDHP any time other than January 1. Per the IRS, you must remain an HSA-eligible individual through December 31 of the next calendar year. If you're not sure you'll remain on the plan, you may want to pro-rate your contribution amount in order to avoid having the excess added to your gross income and an additional 10% tax on that amount.
- If your insurance coverage changes from individual to family mid-year, you're eligible for the full family contribution limit for that calendar year.
- If your insurance coverage changes from family to individual mid-year, your contribution limit will need to be pro-rated according to how many months you were on each type of insurance coverage.

Options for Paying Yourself Back from Your HSA

FOR QUALIFIED MEDICAL EXPENSES PAID WITH NON-HSA FUNDS

1. Use free **Online Bill Pay** to request a check be sent to you.
2. Use free **Online Account to Account Transfer** to transfer funds between accounts at other financial institutions and your HSA.
3. **Write an HSA check** to yourself.
4. **Visit an Old National Bank Branch or ATM** to make a withdrawal. There is no fee for withdrawals at an ONB Branch or ATM. See our Branch/ATM locator feature at **theHSAauthority.com**.[1]
5. Complete and submit a **Withdrawal Authorization Form** found under **Forms** at **theHSAauthority.com** or through online banking.

[1]Foreign ATM fees may apply

Once you've opened your account, you'll receive your debit card in the mail.

Enhanced card benefits[1] include:

- NEW Contactless Pay for quick and safe Tap & Go® shopping
- Improved Card Security with Card Controls and Automated Fraud Monitoring, and more!

[1]Certain restrictions, exclusions and limitations apply. For complete details, see the Mastercard Guide to Benefits that will be provided with your new card.

What If...

You receive a medical bill or are paying for a prescription at the pharmacy and you want to use funds from your HSA.

Pay using your HSA debit card, HSA checks or through online bill pay.

You're at the pharmacy and realize you don't have your HSA debit card, checks, or you don't have enough funds in your Health Savings Account.

Pay for the purchase with personal funds and later reimburse yourself using one of the "Options for Paying Yourself Back from Your HSA" listed at left.

You're faced with a medical emergency and do not have enough in your HSA to cover your portion of the hospital bill.

OPTION 1: Ask provider to set up a payment plan. As funds are deposited into your HSA make payments to the provider using your HSA debit card, online bill pay or checks.

OPTION 2: Pay with another personal checking account, savings account or credit card. Reimburse yourself as funds accumulate in your HSA. Many providers will agree to offer a discount for paying the bill in full.

You're required to pay for treatment at the time of service. Later you receive a reimbursement check from the provider.

OPTION 1: Cash the check and pay for other eligible medical expenses and save those receipts.

OPTION 2: Mail the check to Old National Bank for deposit to your HSA noting it is a REIMBURSEMENT DEPOSIT.

You purchase groceries and a prescription. How should you handle the transaction?

OPTION 1: Pay for the groceries separately and use your HSA debit card or checks for the prescription only.

OPTION 2: Pay for everything with non-HSA funds and later reimburse yourself for the medical portion.

The HSA Authority
OLD NATIONAL BANK

PRODUCT FEATURES

Enrollment Fee	**Free** online enrollment
Minimum Opening Balance	None
Annual Fee	None
Service Charge	No monthly service charge
Statement Options	**Free** online statements; nominal charge for paper statements
Interest Rates	Interest rates may vary based on account balance; rates subject to change; for current rates, call our Client Care Center at 888-472-8697
Annual IRS Reporting and Updates	5498-SA (contributions), 1099-SA (distributions) and adjustments for prior year contributions
24/7 Automated Telephone Banking	Toll-free number 800-731-2265
Deposit Processing	Automatic deposit, mail in service or in-person at any Old National location
Mobile App	Access your HSA with The HSA Authority through the **Old National App** available on the App Store, Google Play or Amazon Appstore. **Free** access to balance, account activity, Bill Pay and Mobile Deposit.[2]
Online Banking	**Free** access to view statements, account activity, balance, and front and back of paid checks
Online Account to Account Transfer	**Free** access to transfer funds between accounts at other financial institutions and your HSA
Online Bill Pay	**Free** access to pay bills online through online banking
Debit Card	**Free** debit cards for account owner and authorized signer
ATM Access	**Free** ATM withdrawals at any Old National ATM; fees will apply for ATM withdrawals at non-Old National ATMs; refer to bank fee schedule
Check Fees	No per-check fees; see HSA Debit Card/Check Request Form for current printing fee per order of 30 checks
Certificate of Deposit Options	Available; call Client Care at 888-472-8697 for current rates and terms; FDIC insured
Investment Options[1]	Available; call Client Care at 888-472-8697 for more information; $36 Annual Fee
Bank Service fees (overdraft, stop pay, etc.)	Call Client Care at 888-472-8697 for details

For account opening instructions, see insert or visit our website at **theHSAauthority.com.**

Address: The HSA Authority, Attention: HSA Operations, PO Box 3606, Evansville, IN 47735
Email: info@theHSAauthority.com
Phone: 888-472-8697 | Monday-Friday and Saturday morning

[1]

Not FDIC Insured	No Bank Guarantee	May Lose Value	Not a Deposit	Not Insured by any Federal Government Agency

[2] There are no Old National fees to use Mobile Banking; however, there may be charges associated with data usage on your phone. Check with your wireless carrier for more information. Not all accounts or customers are eligible for Mobile Deposit. Deposits subject to verification and may not be available for immediate withdrawal. See Terms in App for deposit limits and other restrictions.

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 _____

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: _____

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: _____ Date: _____

Custodian

Warrick County School Corporation

Plan Service Provider

The H.S.A. Authority, Old National Bank

2021
WCSC HEALTH CLINIC

Employees (full time or part time) who **do not** receive or elect health insurance benefits from WCSC have the opportunity to access the WCSC Health Clinics.

Employees who would like to take advantage of this opportunity may do so by completing the attached "Health and Wellness Clinic Salary Reduction" form.

For Employees who receive 26 pays per year
Deduction:
$27.00 per pay
$54.00 per month

Employees who do not receive pay over the summer
Deduction:
$36.00 per pay
$72.00 per month

Signing up for this benefit is a commitment through the remainder of the 2021 calendar year. Coverage and payments will continue through December 2021.

Health and Wellness Facility 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 granting access to the Warrick County School Corporation Health facilities.
Please 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 Warrick County School Corporation and authorize your employer to withhold your bi-weekly contributions for "access" to WCSC health facilities (24 pays annually).

Account Holder Information (Please Print)

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

Job Title: _____

Health and Wellness Contribution Election (This contribution will remain in effect until December 31, 2018)

Please check only one of the options below:

☐ I elect to have a bi-weekly payroll deduction in the amount of $27.00 for access to WCSC health facilities.
This election is for employees who receive paychecks during the summer

☐ I elect to have a bi-weekly payroll deduction in the amount of $36.00 for access to WCSC health facilities.
This election is for employees who DO NOT receive paychecks during the summer

Coverage Information

Beginning Access Date for Health facilities per this Agreement _____

Ending Access Date for Health facilities per this Agreement _____

Adoption Agreement/Employee Signature

This document's sole purpose is to establish the employee's desire to have the payroll deduction assigned above withheld as described in order to receive the benefit of having access to the Warrick County School Corporation Health and Wellness facilities. 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 described.

Signature of Employee: _____ Date: _____

Employee Date of Birth: _____ Employee SSN: _____

Employer Signature

The employee's election to have access to WCSC Health and Wellness facilities via payroll deduction is acceptable as of the date shown below:

Authorized Signature: _____ Date: _____

DENTAL INSURANCE HRI/PARAMOUNT

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

Warrick County Schools
2022 Open Enrollment
HRI / Paramount Dental

Health Resources Inc. dba Paramount Dental is proud to offer dental benefits for the employees of Warrick County School District. We are the same dental insurance company you've known for years, only the name has changed.

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 your out of pocket responsibility. You are always welcome to request Paramount's provider relations team reach out to your out-of-network dentist to become a contracted provider.
To see a full list of Network Dentists, visit https://www.insuringsmiles.com/FindADentist.

Plan 6B offers many covered procedures, including 100% coverage for 2 routine exams, cleanings and fluoride per 12-month period. There are many other preventive and diagnostic procedures covered at 100% as well as many basic and major procedures covered at 50%. Coverage for children's orthodontics, not to exceed $41.70 benefit payment per month up to 2 years or $1000 lifetime max per covered dependent to age 26 is also available with this Plan. Please refer to your Member Plan Book for a comprehensive listing of ALL covered procedures with any limitations and restrictions at InsuringSmiles.com. Other Plan features include:

No Deductibles	No Claim Forms	No Waiting Periods
No Pre-Existing Conditions	No Missing Tooth Exclusions	Large network of participating dentists

Member Enrollment Requirements

The Enrollment Application Form (front and reverse sides completed) for New Enrollments and Changes to current coverage are required to be returned to your school's office no later than November 1, 2021.

Plan Name:	Plan 6B	
Annual Maximum:	$1000	
Ortho Maximum:	$1000	
Tier	**Bi Weekly Rate (24 pays)**	**Monthly Rate**
Employee Only	$15.12	$30.24
Employee + 1	$31.12	$62.24
Family	$51.12	$102.24
Payroll deductions start In December on a Pre-Tax basis providing additional tax savings.		

- Currently enrolled employees, who have no changes, complete NO forms. Coverage will automatically renew.
- Eligible employees who do not currently participate may now enroll in the voluntary group dental plan for the Plan period of January 1, 2022 - December 31, 2022 by completing the enclosed Enrollment Application and AND the Payroll Authorization Form on the reverse side of the Enrollment Application
- If you are currently enrolled and need to change or cancel dependent coverage, complete the enclosed Enrollment Application AND the Payroll Authorization Form on the reverse side of the Enrollment Application.

For additional Information, contact:
Paramount Dental's authorized Agent - Tom Southwood - 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

Insuring Smiles for the Whole Family!

PARAMOUNT DENTAL
Affiliate of ProMedica

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: Warrick County School Corp.	**Group Number:** 941112793400	**Site Location / Cabinet:**	**DHO Plan:**

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

EMPLOYEE	**PRODUCT**					
☐ Add ☐ Term ☐ Update	☐ Dental ☐ Waive	Social Security Number		Employee Hire Date		
		Last Name	First Name	MI	Birth Date	
		Home Address	City		State	Zip

SPOUSE / PARTNER	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ Dental ☐ Waive	Social Security Number	Birth Date		Other Dental Coverage? ☐ Yes ☐ No
		Last Name	First Name	MI	Is Other Policy Primary? ☐ Yes ☐ No

DEPENDENT	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ 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	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ 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	**PRODUCT**				
☐ Add ☐ Term ☐ Update	☐ 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______________

WARRICK COUNTY SCHOOLS

Employee Benefit Election/Salary Reduction Agreement

Emp # #= Number of Deductions

Employer: Warrick County School Corporation **Other Information:**

Employee: **Social Security #:**

Address: **Home Phone #:**

Email:

Plan Year Beginning: 1/1/2021 **Ending:** 12/31/2021

I have elected participation in the following benefits:

Status	#	Effective Date	Benefit/Company	Section 125 Before-Tax	After-Tax/ Payroll Deduct	Employer Paid **	403(b)/457(b) Annuity
			Medical / AFA				
			*Disability / AFA				
			Cancer / AFA				
			Group Life / AFA				
			Dental / AFA				

Totals :

* This benefit will result in taxable income if selected on a before-tax basis.

** When indemnity premiums are pre-taxed, benefits paid in excess of the medical expenses incurred could be taxable.

*** Any amount in the Employer Paid column reflects an annual contribution.

**** Annuity amounts shown above are for informational purposes only. This form is not an authorization to reduce salary for 403(b) and 457(b) plans. A 403(b) or 457(b) salary reduction form must be completed and submitted to the employer.

Terms and Conditions

I hereby authorize the above payroll reductions as my contribution to my Employer's Section 125 Cafeteria Plan.

I understand that:

1. **Changes in the cafeteria plan elections (other than with respect to the Health Savings Account) can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; change in employment status; dependent satisfies or ceases to satisfy dependent eligibility requirements; residence change, cost or coverage changes) and such other events as would permit a revocation or change of election under IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. In most cases NO change may be made in the Medical Expense Reimbursement Account except for termination of participation of employment. For special rules affecting your plan, please contact your employer. FICA taxes are not paid on Section 125 salary reduction. Therefore, your social security benefits at retirement may be reduced. Unused funds remaining in the flex spending accounts at the end of the current plan year will be forfeited.**

2. **Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.**

   If I have elected the Health Savings Account benefit, I certify that I have met all the Health Savings Account eligibility requirements, which have been separately disclosed to me, and that I will notify the Employer immediately in writing if I cease to meet any of the conditions for Health Savings Account eligibility during any month of the plan year.

This authorization replaces any previous authorization I have made.

Date: _____ Signature of Employee: _____

LIFE INSURANCE

Click here to clear form.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690

GROUP LIFE INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 24-000003-00

Employer/Policyholder Name Warrick County School Corporation

300 East Gum Street, P.O. Box 809 (Street Address) | Boonville (City) | IN (State) | 47601 (Zip Code)

Employee Occupation/Job Title

Employee Date of Employment

Effective Date of Coverage

☑ Full Time Employee ☐ Part Time Employee

$_____/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

N/A
Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

Name Sex ☐ M ☐ F

Street Address | City | State | Zip Code

Home Telephone Number | Date of Birth | Marital Status

II. BENEFITS (Please check if you wish to enroll)

Please contact your HR representative with any questions

	Yes	No	Indicate the benefit amount
Employee Basic Life/AD&D	✔		$50,000
Employee Supplemental Life/AD&D			
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Life*	[1] Please provide the **name** and **birth date** for **each dependent** below.		
Option 1			Spouse[1]: $10,000 Child(ren)[1]: $5,000
Option 2			Spouse[1]: $25,000 Child(ren)[1]: $10,000
*Spouse up to age 70, Child(ren) up to age 19 or 25 if full time student.			

[1] ***List Dependents' names and birthdates (use another page if needed).***

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

LONG TERM DISABILITY

Warrick County School Corporation

LTD ENROLLMENT

Effective Date:

Warrick County School Corporation
Policy Number: LK-966638

Employer Paid Benefit

Plan documents can be found on the WCSC Website.

"The certificate describes coverage provided to persons who are eligible and who have been properly enrolled under the terms of the policy, and that the terms of the master policy are controlling."

Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ (To be completed by employer)

Full Name :

E-Mail :

Address :

City, State, Zip:

Employee Assistance Benefits

NY Life offers Employee Assistance to our employees some services are fee based. More information on these services can be found on the WCSC website or by contacting Amanda Vollman, Benefits Facilitator at 812-897-6038.

- Health Advocacy Services
- Life Assistance Program
- Identity Theft Protection
- Will Prep Service
- My Secure Advantage Program/Financial Wellness

INPRS
INDIANA PUBLIC RETIREMENT SYSTEM

INPRS

INDIANA PUBLIC RETIREMENT SYSTEM

ENROLLMENT INFORMATION			
Name (first, middle initial, last)		Date of birth (month, day, year)	
Social Security Number		Gender	Current marital status
		☐ Male ☐ Female	☐ Single ☐ Married
Address (number & street, city state, and ZIP code)			
Home telephone number	Other telephone number	E-mail address	
Date of full-time employment in this TRF or PERF-covered position and start of mandatory contributions (month, date, year)			
Position or title	Is this an elected position?	Has this employee been a member of INPRS before?	
	☐ Yes ☒ No	☐ Yes ☐ No	
Name of employer			
Warrick County School Corporation			
Address of employer (number and street, city, state, and ZIP code)			
300 E. Gum Street P. O. Box 809 Boonville, IN 47601			
Telephone number of employer		Account number of employer	
812-897-6038		TRF: 0087001 -OR- PERF: 0950000	

INDIANA PUBLIC RETIREMENT SYSTEM

ONE NORTH CAPITOL, SUITE 001 ▲ INDIANAPOLIS, IN 46204

Congratulations on your new position!

You are now a member of the Indiana Public Retirement System's (INPRS) Teachers' Retirement Fund (TRF) and have some choices to make regarding your retirement benefits. We have provided some important information to make your selections as easy as possible.

You have an option between two benefit plans: the **TRF Hybrid Plan** and the **My Choice: Retirement Savings Plan.** The TRF Hybrid plan consists of two parts – a Defined Contribution (DC) Account and a Defined Benefit (DB). The TRF My Choice: Retirement Savings Plan is a Defined Contribution (DC) Account, which you can invest while working and use to purchase an annuity for lifelong retirement income. From your start date, you have 60 days to select your preferred plan. If you do not decide within 60 days, you will default into the TRF Hybrid Retirement Plan. Once you have made a choice or defaulted, you cannot change plans.

You may also want to review the "Which option is best for you?" side by side comparison in this enrollment package. For more information on DC accounts, watch our "What is a Defined Contribution (DC) Account?" video at http://bit.ly/whatisINPRSDC.

As you are looking over which plan is right for you, be sure to think about your investment options. From day one, *the money in your DC is yours to control*. Take our award-winning Investing 101 course at http://bit.ly/INPRSInvesting101 to learn more about investing and find out what kind of investments match up with your goals.

In the coming weeks, you will receive your account login information in the mail. You will need this information in order to log on to your INPRS account and select your plan. When you log on, be sure to provide your email address and select the electronic communication option. This will allow you to receive our quarterly newsletters, account statements and other important information electronically.

We encourage you to look at all your retirement plan options before making a decision. If you have any unanswered questions after reviewing this information, please contact us at (844) GO-INPRS or (844) 464-6777 Monday through Friday from 8 a.m. to 8 p.m. EST.

Please follow us on social media to stay informed on what's new at INPRS. We're on Facebook, Twitter, Instagram, LinkedIn and YouTube.

Again, congratulations on your new position and welcome to INPRS!

7/1/2020

INDIANA PUBLIC RETIREMENT SYSTEM

Which option is right for you?
For TRF Members

As a new employee entering into TRF-covered employment, you have 60 days from your start date to choose between two retirement options. You will receive a PIN number in the mail with instructions on how to access your online account in order to make an election. If you do not make a choice within the 60 day election window, you will default to the TRF Hybrid plan. Your plan selection is irrevocable, regardless of whether you choose between the two options or default.

Plan Type	TRF Hybrid Plan Defined Benefit (DB) and Defined Contribution Account (DC)	My Choice: Retirement Savings Plan
Election	Default option if no election is made in 60 days	60 days to choose this plan
Contributions	DC (employee share): Fixed 3% of gross wages/May elect to make post-tax voluntary contributions not to exceed 10 percent of gross wages (100% vested from date of hire)	
	5.5% towards DB – effective July 1, 2020 to June 30, 2021* (employer share – funds the pension benefit obligations of the employer)	5.3% crediting rate– effective July 1, 2020 to June 30, 2021* (employer share toward DC account, requires vesting)
Vesting	For fixed DC contributions of 3% of gross wages: 100% vesting from date of hire	
	DB: 10 years of service	Variable DC percent: 20 percent vesting increases for every full year of participation up to 5 years
Benefit Eligible	For fixed contributions toward DC of 3% of gross wages (employee share): Available upon separation of employment subject to limitations.	
	DB: Available upon separation of employment and age and service requirements: ■ age 50 to 59 and 15 years of service (early retirement with reduced benefits) ■ age 55 and 30 years of service ■ age 60 and 15 years of service ■ age 65 and 10 years of service ■ age 70 and 20 years of service**	Variable percent: Employer share available upon separation of employment and based on full years of participation: 1 year = 20% 2 years = 40% 3 years = 60% 4 years = 80% 5 years = 100%
Retirement Options	DB is a lifetime retirement benefit that can be taken by itself. The DC is available as a lump sum, a direct rollover to another plan or used to purchase a lifetime monthly annuity.	Vested portion of account balance available as a lump sum, partial withdraw, or direct rollover or can be used to purchase a lifetime monthly annuity (minimum account balance required).

*Regardless of the set annual rate, the TRF Hybrid defined benefit amount is an average of annual compensation based on 20 quarters, years of service and a multiplier of 1.1 percent. This rate is a variable percentage set annually by the INPRS board. Contribution amounts covering unfunded pension liability are not made to My Choice: Retirement Savings Plan accounts. For more information on employer contribution rates, visit www.in.gov/inprs/ercontributionrates.htm.

**See the Teachers' Retirement Fund Member Handbook.

7/1/2020

INPRS MY CHOICE Retirement Savings Plan

TRF AT A GLANCE

Contributions

Mandatory 3 percent employee share of gross wages paid by employer.

Employer crediting rate portion of employer share is 5.5 percent. Members must meet vesting requirements.[1, 2]

Voluntary Contributions
- Employee may do direct rollovers from qualified plans

Voluntary Contributions, continued
- Employee can elect up to 10 percent of gross wages to contribute additional money
- Employee's voluntary contributions are post-tax.

Vesting

The employee share is fully vested upon hire.

The employer share is based on full years of participation:
- 1 year = 20 percent
- 2 years = 40 percent
- 3 years = 60 percent
- 4 years = 80 percent
- 5 years = 100 percent

Eligibility for Plan Participation

You must be a new TRF member entering into TRF-covered employment on or after July 1, 2019. You will be able to choose membership in either the Hybrid or My Choice: Retirement Savings Plan. [3]

Eligibility for Disability Benefit Payment

- Qualified for Social Security disability benefits and furnished proof of qualification
- Received a salary from a position covered by the My Choice: Retirement Savings Plan within 30 days of social security eligibility date
- Vested in employer share beginning at one year of participation

After demonstrating disability, member can withdraw funds.

Withdrawal is limited to the vested portion of the employee's account balance with this option.

Investment Options

Members direct their investments in a combination of any of eight funds (see list below). The default investment fund is the target date fund based on a member's estimated retirement date.

- Money Market Fund
- Fixed Income Fund
- Large Cap Equity Index Fund
- Small/Mid Cap Equity Fund
- International Equity Fund
- Inflation-Linked Fixed Income Fund
- Stable Value Fund
- Target Date Funds

[1]My Choice: Retirement Savings Plan employer contribution rates are effective July 1, 2020 to June 30, 2021.
[2]Contribution amounts covering unfunded pension liability are not made to My Choice: Retirement Savings Plan accounts.
[3]More information is available in the TRF My Choice: Retirement Savings Plan Handbook.

INPRS INDIANA PUBLIC RETIREMENT SYSTEM

7/1/2020

INPRS MY CHOICE Retirement Savings Plan

TRF AT A GLANCE

Account Information

Daily valuation allows members to manage their Defined Contribution Account investments on a daily basis.

Withdrawals Before Retirement

Members who are actively employed in a covered position may not withdraw the account balance.

Members can withdraw their rollover account balance at any time.

Members who have demonstrated disability can withdraw the vested amount of their account balance.

Available only when disabled or separated from service

- May leave account invested in TRF, or receive a distribution
- Rollover to qualified plan or other eligible retirement account
- No loans

Income and Options at Retirement

Members who meet the age and minimum balance requirements must make their distribution elections on the retirement application.

Choices determine payments

- May defer payment until April following age 72, if you are not actively employed in a covered position.
- May choose lump sum, partial withdrawal or rollover distribution
- Members who have reached age 62 may choose monthly payment for annuity
- Amount of distribution determined by account balance, taxes withheld, and distribution option chosen

Beneficiaries/ Spousal survivors

Payment

- After death of a member, designated beneficiary(ies), or the estate if there are no designated beneficiaries, receives the vested portion of the member's account balance.

Balance payment

- Receives total accumulated amount after death of member.

FOR YOUR BENEFIT

This handout is an overview of the TRF My Choice: Retirement Savings Plan provisions. Complete details of the plan's provisions are available in the current member handbook. You may read it or print your own copy from the INPRS website at **www.inprs.in.gov**. You may also request a copy in writing or by calling our toll-free number, (844) GO-INPRS.

Keep your information current. Report any changes in your name, address or beneficiary choices directly to INPRS. This is NOT something your employer can do for you. To change your beneficiary, name or address information, log on to your online member account by visiting **myINPRSretirement.org**.

Every attempt has been made to verify that the information in this publication is correct and up-to-date. Published content does not constitute legal advice. If a conflict arises between information contained in this publication and the law, the applicable law shall apply.

Warrick County School Corporation
Sick Leave Bank Election Form

Article V of the Contractual Agreement ("Agreement") between the Warrick County Board of School Trustees and the Warrick County Teachers Association (NEA) provides for a voluntary Sick Leave Bank ("Bank"). The Bank is available to employees as identified in the Agreement and benefits are specified in the Agreement.

Employees who wish to be members of the Bank shall contribute one (1) day of their accumulated sick leave to the Bank upon enrollment. Should the balance of the Bank days at any time fall below 100, each member shall then contribute one (1) additional day to the Bank.

☐ I elect to participate in the bank and authorize Warrick County School Corporation to transfer one (1) day of my accumulated sick leave to the Bank; further, I understand that I may be required to contribute an additional day(s) in the future as described in the Agreement.

☐ I waive membership in the Bank and understand that, by doing so, I will not be eligible for any Sick Leave Bank benefits. I also understand that by declining participation in the Bank now when first eligible, I am unable to enroll in the Bank at any later date.

Employee Printed Name

Employee Signature

Date

WARRICK COUNTY SCHOOL CORPORATION

403 (B) Plan Availability

As an eligible employee of the Warrick County School Corporation, you are permitted to participate in a 403(b) tax deferred retirement program. This letter is not inteneded to solicit contributions but rather to inform or remind employees of WCSC of the universal availability of this employer-offered plan.

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement plan available to employees of educational institutions and certain non-profit organizations. In this plan, you can make pre-tax contributions for retirement savings. Distributions generally are only available when you reach age 59 1/2 or experience a severance of employment. However, distributions can also be available in the event of financial hardship, death, or disability. Short-term needs can sometimes be met by non-taxable loans.

Why contribute to a 403(b)?

Participating in your plan can provide a number of benefits, including:

- **Lower taxes today.** Your 403(b) contributions are made on a pre-tax basis which can greatly reduce your current income tax bill. For example, if your federal marginal income tax rate is 25% and if you contribute $100 a month to a 403(b) plan, you've reduced your federal income taxes by roughly $25 (assuming a 25% tax bracket). In effect, your $100 contribution costs you only $75. The tax savings can grow with the size of your 403(b) contribution.

- **Tax-deferred growth.** Your account in the 403(b) plan is tax deferred. This means that your account can grow tax-free until the time of withdrawal.

- **Enhanced Retirement.** Other sources of retirement income, including state pension plans and, if applicable, Social Security, often do not adequately replace a person's salary upon retirement. A 403(b) plan can provide a healthy supplement to an employee's retirement income.

If interested, please contact one of the approved 403(b) vendors.

AIG/Valic: Sheri Barron - 812-455-9515 sheri.barron@aig.com
David Dassell - 812-202-2297 david.dassell@aig.com
Ameriprise: 800-862-7919
Aspire: 800-634-5873
Horace Mann: 800-999-1030

WCSC EMPLOYEE BENEFITS CHECKLIST

Please return all forms to WCSC Benefits Office.

- [ ] **Anthem** – Health Insurance Enrollment Form
  Note: If you are NOT enrolling in a medical plan, you must still complete the waiver.

- [ ] **Paramount Dental** – Dental Enrollment Form
  Note: If you choose NOT to enroll, you must enter your name on the form and select "DECLINE COVERAGE"

- [ ] **Warrick County Schools Employee Benefit Election/Salary Reduction Agreement** - please sign and date, this form enables us to payroll deduct your non-taxable benefits (Section 125)

- [ ] **Symetra**- Life Insurance Enrollment Form

- [ ] **NY LIFE**-Long Term Disability

- [ ] **INPRS**-Indiana Public Retirement System

- [ ] **Sick Leave Bank Election Form**

Please review all forms for accuracy and completion before submitting.

Employee Name: _____ School: _____

Questions? Please contact Amanda Vollman at 812-897-6038 or email avollman@warrick.k12.in.us

Clear Form