Summary of Fringe Benefits for Certified Staff

HEALTH & VISION INSURANCE

Single $9,800/Multi-Person $14,000/Family $17,000/Dual Employee $19,200 benefit per year provided by the Corporation

2023 SEMI-MONTHLY PREMIUMS-(AMOUNT PAID BY EMPLOYEE)

Anthem Health & VSP Vision

	Plan 5	Plan 6
Single	$99.00	$5.00
Member/Spouse	$393.00	$128.00
Member/Child(ren)	$435.00	$145.00
Family	$487.00	$154.00

*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

Notice of Availability of

Important Documents

Warrick County School

Corporation

Dear Employee,

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

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

Clickable LINK: WCSC Important Benefit Documents - Notifications
LINK: https://www.warrick.k12.in.us/572331_3

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

Sincerely

Amanda D. Vollman

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

WARRICK COUNTY SCHOOL CORPORATION

2023 Health Insurance Renewal

Not too shabby health insurance renewal!

The following is a summary of the plan design costs available for 2023. Use this information to select your health plan from among the two (2) options. Plan #'s 5 and 6 are exactly the same as 2022. Pay special attention to the column labeled "2023 Semi-Monthly Employee Contribution." This is the amount that is deducted from your paycheck 24 times from December 2022 through November 2023 (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	2020 Semi-Monthly Employee Contribution	2021 Semi-Monthly Employee Contribution	2022 Semi-Monthly Employee Contribution	2023 Semi-Monthly Employee Contribution (Dec-Nov)	2022 Semi-Monthly Employee Contribution Dual-Members	2023 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$1,015	12	$12,180	$9,800	$2,376	$198	$89	$96	$96	$99	NA	NA
Emp/Sp	$1,952	12	$23,424	$14,000	$9,432	$786	$338	$386	$385	$393	$168	$176
Emp/Child	$2,037	12	$24,444	$14,000	$10,440	$870	$364	$427	$426	$435	NA	NA
Family	$2,390	12	$28,680	$17,000	$11,688	$974	$412	$474	$471	$487	$379	$395

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	2020 Semi-Monthly Employee Contribution	2021 Semi-Monthly Employee Contribution	2022 Semi-Monthly Employee Contribution	2023 Semi-Monthly Employee Contribution (Dec-Nov)	2022 Semi-Monthly Employee Contribution Dual-Members	2023 Semi-Monthly Employee Contribution Dual-Members (Dec-Nov)
Emp	$827	12	$9,924	$9,800	$120	$10	$7	$0.01	$0.01	$5	NA	NA
Emp/Sp	$1,423	12	$17,076	$14,000	$3,072	$256	$135	$124	$121	$128	$0	$0
Emp/Child	$1,457	12	$17,484	$14,000	$3,480	$290	$143	$139	$137	$145	NA	NA
Family	$1,724	12	$20,688	$17,000	$3,696	$308	$157	$153	$148	$154	$56	$62

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

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

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

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

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

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

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

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

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

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

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

This does not account for dual employee contributions.

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

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

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

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

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

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

Single Plan Comparison

Plan Design	Semi-monthly Payment	# of Payments	Total Employee Paid Premium	Credit for Employer Contribution	Maximum Deductible	Premium + Deductible		Co-insurance to Max Out-of-Pocket	Amount Employee will spend without Copays	Maximum Co-pays	Amount Employee will pay after Copays	
H.S.A. Plan 5	$99.00	24	$2,376.00		$3,000.00	$5,376.00	Pay 0% after deductible	$0.00	$5,376.00	1000	$6,376.00	
H.S.A. Plan 6	$5.00	24	$120.00		$5,000.00	$5,120.00	Pay 0% after deductible	$0.00	$5,120.00	950	$6,070.00	*

Family Plan Comparison

Plan Design	Semi-monthly Payment	# of Payments	Total Employee Paid Premium	Credit for Employer Contribution	Maximum Deductible	Premium + Deductible		Co-insurance to Max Out-of-Pocket	Amount Employee will spend without Copays	Maximum Co-pays	Amount Employee will pay after Copays	
H.S.A. Plan 5	$487.00	24	$11,688.00		$6,000.00	$17,688.00	Pay 0% after deductible	$0.00	$17,688.00	2000	$19,688.00	
H.S.A. Plan 6	$154.00	24	$3,696.00		$10,000.00	$13,696.00	Pay 0% after deductible	$0.00	$13,696.00	1900	$15,596.00	*

*** 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

Plan #5

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

IPST – Warrick County School Corp

Your Network: Blue Access

Effective: 01/01/2023

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
Overall Out-of-Pocket Limit	$4,000 person / $8,000 family	$12,000 person / $24,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 0% coinsurance after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	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 *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	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
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 Care at a Facility		
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
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory 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
Ambulatory 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 *Cornea transplants 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
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	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
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and 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
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and 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

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$30 copay per prescription after deductible is met (retail) and $75 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription after deductible is met (retail) and $180 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $200 per prescription after deductible is met (retail and home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)

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.

WCSC
$5,000 DEDUCTIBLE
ANTHEM
PLAN #6

Your summary of benefits

Anthem

Plan # 6

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

IPST – Warrick County School Corp.

Your Network: Blue Access

Effective: 01/01/2023

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
Overall Out-of-Pocket Limit	$5,950 person / $11,900 family	$20,000 person / $40,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance per visit after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 0% coinsurance after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	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 *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	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
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 Care at a Facility		
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
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory 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
Ambulatory 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 *Cornea transplants 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
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	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
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and 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
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and 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

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$30 copay per prescription after deductible is met (retail) and $75 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription after deductible is met (retail) and $180 copay per prescription after deductible is met (home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $200 per prescription after deductible is met (retail and home delivery)	50% coinsurance, min $60 after deductible is met (retail) and Not covered (home delivery)

VISION INSURANCE
VSP

A Look at Your VSP Vision Coverage

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

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

vsp vision care

Value and savings you love.

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

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

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

Quality vision care you need.

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

Using your benefit is easy!

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

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

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

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

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

Your VSP Vision Benefits Summary

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

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2023

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$5	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	
FRAME[+]	• $220 featured frame brands allowance • $200 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
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		

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

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

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

Dear HSA Participant:

Your UMB Health Savings Account (HSA) is an excellent tool for managing your health, your family's health and your financial health. The UMB HSA allows you to pay for your current healthcare expenses or to save money for future qualified expenses. Opening your UMB HSA is easy. You can complete all of your enrollment forms online!

Online Enrollment
With online enrollment, you can open your UMB HSA in the comfort of your own home or anywhere you have access to the Internet. Just click this link to our enrollment site:

HSA Enrollment Link
Or follow these instructions:
hsa.umb.com ; click "Open an HSA" under the Individual tab;
Enter THA0001 ~ 160368

Online Account Access
After you enroll, you will receive your account number and debit card in the mail within 5 to 7 business days with detailed instructions on how to access your account online via the UMB HSA Website.You will need your account number and debit card number to set up your password. Online access will allow you to view your account balance; reimburse yourself for medical expenses incurred without the debit card; download forms; and access a variety of other internal and external links to resources and tools to help you manage your HSA. This is also where you can enroll in the UMB HSA Saver®* investment option.

Contributions to the Account
The annual contribution limits are set by the IRS. Current limits can be found by clicking here . The IRS also allows for an additional contribution of $1,000 for those 55 or older. Employees may make pre-tax contributions through payroll deduction and anyone can contribute post-tax funds by using the HSA Contribution Form or by selecting "Make a Contribution" to electronically transfer funds from your personal banking account to your UMB HSA through the secure online HSA website.

Accessing HSA Funds
You will be able to access your HSA funds by using your health care Visa debit card to pay for qualified medical expenses. If you use another form of payment, you may reimburse yourself from your UMB HSA by logging in online to your account and selecting reimbursement tool. This allows you to transfer money out of your HSA and into a personal bank account. For a full list of eligible expenses, please see the Useful Links on our Web site.

HSA Account
Once you have enrolled, UMB offers a Deposit Account and the UMB HSA Saver® investment option. You will automatically be enrolled in the Deposit Account. You may elect the investment option after you meet the eligibility requirements, as described on the web site. It's your choice. It's your UMB HSA!

1. **HSA Base Account.** This FDIC-insured account pays tiered interest rates based on your balance in the account.
2. **UMB HSA Saver Investment Option*.** This option allows you to invest in various mutual fund offerings.

Customer Service
UMB provides all customer service regarding the HSA, debit card, and investments through the Web site and toll-free number **(866) 520-4HSA**.

Thank you for selecting the UMB HSA!

Investments in securities, through UMB HSA Saver are:
Not FDIC Insured • May Lose Value • No Bank Guarantee

**UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Investment Management is a department of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation.*

UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program. UMB Custody Services is a division of UMB Bank, n.a.

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
UMB Bank

2023 WCSC DEACONESS AT WORK HEALTH CLINIC ACCESS

Full Time and Part Time Employees have the opportunity to access the WCSC Deaconess at Work 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. Coverage is for the employee only. We do not offer "clinic only" family access.

Return the form via email or school mail to Amanda in the Benefits Office before the deadline in your welcome email.

**Access to the clinic is not considered "health insurance" - it strictly allows you to access the Deaconess at Work Clinics.*

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 (PT Cafe & PT Custodians)

Deduction:
$36.00 per pay
$72.00 per month

Signing up for this benefit is a commitment through the remainder of the 2023 calendar year. You will need to sign up again at open enrollment for the 2024 calendar year.

Please contact Amanda Vollman in the Benefits Office with questions
avollman@warrick.k12.in.us or 812-897-6038

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, 2023)

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 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 deduction per pay, 24 times/year
Employee + 1 Dependent	$31.12 deduction per pay, 24 times/year
Employee + Family	$51.12 deduction per pay, 24 times/year

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

- Employees who have no changes with their dental plan do not need to do anything, coverage will automatically renew.
- Eligible employees who do not currently participate may now enroll in the voluntary group dental plan period of January 1, 2023 - December 31, 2023 by completing the Paramount Dental Enrollment Application
- **If you are currently enrolled and need to change or cancel coverage, complete the applicable information on the Paramount Dental Enrollment Application (Example: Term or Update in the appropriate Employee, Spouse/Partner, Dependent boxes on the Enrollment Application)**

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

PARAMOUNT DENTAL

Affiliate of ProMedica

Product Summary Guide for Warrick County School Corporation

DHO 6 (January - December)

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

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

Limited Orthodontic Treatment

Interceptive Orthodontic Treatment

Comprehensive Orthodontic Treatment

Treatment to Control Harmful Habits

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

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

To find a dentist visit: InsuringSmiles.com/FindADentist

PARAMOUNT DENTAL
Affiliate of ProMedica

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

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

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

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

EMPLOYEE	**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:	**Ending:**

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