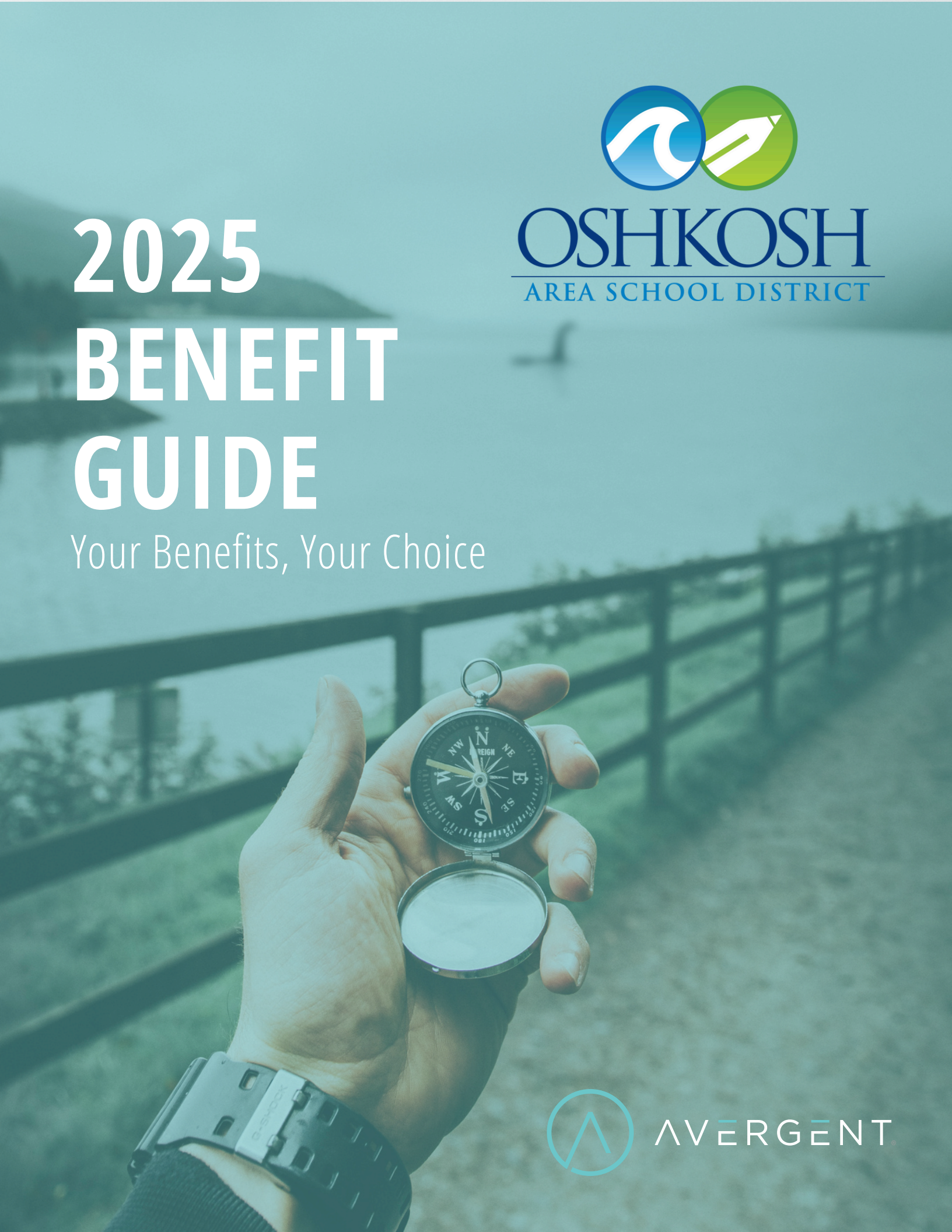
2025 BENEFIT GUIDE

Your Benefits, Your Choice

OSHKOSH AREA SCHOOL DISTRICT



AVERGENT

WELCOME TO YOUR BENEFIT GUIDE

EMPLOYEE ELIGIBILITY

All full-time employees working **30 or more hours per week** will be eligible for benefits. All coverages will take effect on your date of hire.

These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

BENEFIT HIGHLIGHTS

- Eligibility & Enrollment
- Contact List
- Medical
- Collaborative Care
- Pharmacy
- FLEX Spending
- Three Waves Clinic
- Dental
- Vision
- Basic & Voluntary Life / AD&D
- Short & Long-Term Disability
- Accident & Hospital
- EAP
- Required Notices

DEPENDENT ELIGIBILITY

Medical, Dental, Vision:

Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.

CURRENT EMPLOYEES

Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

NEW EMPLOYEES

This is your chance to elect benefits and enroll yourself and your eligible dependents. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year's open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

DEFINITION OF "ELIGIBLE DEPENDENTS"

The below definitions refer to Medical, Dental, and Vision Coverages.

• Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed.
• The employee's dependent children at the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
• Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree. Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

CONTACTS

INSURANCE CARRIERS AND ADMINISTRATORS

What	Who	Contact Information
Benefits, Medical & Prescription Claims, Care Coordination	Oshkosh Benefits Team	877-537-6877 oasd.benengage.com
Dental	Delta Dental	800.236.3712 deltadentalwi.com
Vision	Delta Dental	800.521.3605 eyemed.com/member
Basic Life |AD&D Voluntary Life |AD&D	Voya Financial (Teachers & Administrators)	800.955.7736 voya.com
Basic Life | AD&D Voluntary Life | AD&D	Wisconsin ETF (Food Services, Clerical, Custodians, Para)	877.533.5052 etf.wi.gov
Short Term Disability Long Term Disability	Reliance Standard	800.351.7500 https://rslclaims.com/rslclaims/employee
Accident Hospital	Reliance Standard	800.351.7500 https://rslclaims.com/rslclaims/employee
Life Transitions	Avergent	866.247.5415 avergent.com

ADMINISTRATIVE CONTACT

For questions about enrolling or making changes to the benefits, please contact:

Kathy Jurgensmier
Benefits Manager
920.424.0163
kathryn.jurgensmier@oshkosh.k12.wi.us

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

HEALTH PLAN OVERVIEW

PLAN COVERAGE	MEMBER COST
Individual | Family Annual Deductible	$0 | $0
Individual | Family Annual Out-of-Pocket Maximum	$5,000 | $10,000
Three Waves Clinic | Preventive Care | Premise Health App	$0
Office Visits: Primary | Pediatric | Specialty | Urgent	$100 | $25 | $150 | $250 Copay
Emergency Room (copay waived if admitted)	$250 Copay
Inpatient or Outpatient Hospital & Facility Services	$1,000 Copay
Pharmacy Tiers: Generic | Preferred Brand Non-Preferred Brand | Specialty	$5 | $40 | $80 | $250 Copays

**Collaborative Care can waive non-emergent, specialty care Copays or benefit limitations. See Collaborative Care FAQ's and Summary Plan Description for full details.*

EMPLOYEE CONTRIBUTIONS PER MONTH (pre-tax)

Employee Only: $50
Family: $100

YOUR HEALTH PLAN INCLUDES

COLLABORATIVE CARE

OSHKOSH AREA SCHOOL DISTRICT

Benefits Team

Healthcare can be frustrating and difficult to navigate. When you have new, ongoing or complex symptoms and need guidance, we're here to help you avoid misdiagnosis, unnecessary treatment and paying too much.

We are a nurse concierge team with access to 4,000+ specialists, physicians and pharmacists across the nation, here to help you get to the right care.

When we research your options and help you coordinate your care, we can possibly even waive your copays.

Collaborative Care Nurse to help research and coordinate care

What do I do?
Where do I go?
What will it cost?

Access to the nations best: Physicians, surgeons, pharmacists, physical and mental health therapists

- *No Cost Expert Medical Opinion*
- *Complex Care research and coordination*
- *Chronic Disease management*
- *High cost medication review*
- *Surgery & Imaging review and navigation*
- *Alternative therapies*
- *Waived copays*
- *and more....*

RIGHT CARE
RIGHT PLACE
RIGHT PLACE
RIGHT PRICE

CALL THE NUMBER ON THE FRONT OF YOUR ID CARD FOR MORE!

avergent.com | 866-247-5415 | help@avergent.com

Frequently Asked Questions

What is my Benefits Team?
Your health plan comes with a team of dedicated benefit experts who know your benefit plan and can help guide you to answers, about coverage and claims, or resources for care, including your Collaborative Care benefit.

What is Collaborative Care?
Your plan gives you access to a team of benefit and clinical experts who will work together to help you assess your care options and choose the highest quality providers.

How do I access Collaborative Care?
Simply call the Benefits Team number on your ID card or in your app

Does Collaborative Care replace my Primary Care Physician or Specialist(s)?
Your PCP or Specialists play a key role in your care, as they provide the care. Collaborative Care is here to support existing relationships and ensure you're getting the most from those relationships, in addition to finding the clinicians and facilities that will get you the best outcome.

Does this cost me anything?
Medical opinions, care coordination and research and condition management over and above existing treatments are no cost to you and can waive or reduce your out of pocket expenses on the right care. Should you choose to continue planned care or treatment, your benefits remain the same.

Do I have to follow the advice of Collaborative Care?
Collaborative Care will provide you with options. You can choose how you want to proceed. These options will always have the intent of providing you with high quality, affordable care

What can Collaborative Care help me with?
- Non-urgent care (if you need a care issue resolved within 24 hours, we cannot support; utilize your telehealth option within your Member app or your local Urgent Care clinic)
- Planning for routine lab work, prescriptions and condition management
- Surgical second opinions through independent, board-certified specialists
- Alternative non-surgical therapy options
- And more…

Will Collaborative Care ever proactively contact me?
Yes, they may. Our clinical team works proactively to identify opportunities for better access to care or benefits based on specific conditions. In the event you are contacted, you can be certain it will be to provide assistance.

What information is shared with my employer?
Your Health Plan and Collaborative Care follow all HIPAA guidelines and take the utmost care in securing data and information. Individual health record information is available to Collaborative Care in conjunction with their efforts to assist you in coordinating your care needs and accessing the best benefits.

When should I NOT contact Collaborative Care?
You shouldn't contact Collaborative Care for basic stuff like new ID cards, provider lists, etc. If you are experiencing a medical emergency, always dial 911 go to the nearest Emergency Room. For non-emergent, but urgent matters, your plan offers you 3 ways to access 24/7 telehealth.

Call 877-537-6877 to connect with the Benefits Team.

OSHKOSH AREA SCHOOL DISTRICT

Benefits Team

OFFICE VISIT SERVICES

PLAN COVERAGE	MEMBER COST
Preventative Care: (Adult & child wellness exams, immunizations, age based screenings)	$0
Premise Health App: Urgent Care	$0
Primary Care | Pediatrician	$100 | $25 Copay
Chiropractic	$100 Copay
Urgent Care	$250 Copay
Specialist Care*	$150 Copay

Out of Pocket Maximum includes Medical & Pharmacy: $5,000 per Individual (2x per Family)

**Collaborative Care can waive non-emergent, specialty care Copays or benefit limitations. See Collaborative Care FAQ's and Summary Plan Description for full details.*

HOSPITAL & FACILITY SERVICES

PLAN COVERAGE	MEMBER COST
Emergency Room	$250 Copay
Ambulance (Air or Ground)	$250 Copay
Durable Medical Equipment*	$250 Copay
Labor and Delivery	$1,000 Copay
Inpatient Residential Treatment	$1,000 Copay
Inpatient Room & Board*	$1,000 Copay
Advanced Diagnostics*	$1,000 Copay
Outpatient Surgery*	$1,000 Copay
Skilled Nursing*	$1,000 Copay

Out of Pocket Maximum includes Medical & Pharmacy: $5,000 per Individual (2x per Family)

**Collaborative Care can waive non-emergent, specialty care Copays or benefit limitations. See Collaborative Care FAQ's and Summary Plan Description for full details.*

PHARMACY

TYPE OR TIER	MEMBER COST
Tier 0 - Preventive	$0 Copay
Tier 1 - Generic	$5 Copay
Tier 2 - Formulary Preferred	$40 Copay
Tier 3 - Formulary Non-Preferred*	$80 Copay
Tier 4 - Specialty*	Call 877-537-6877

**Collaborative Care can waive non-emergent, specialty care Copays or benefit limitations. See Collaborative Care FAQ's and Summary Plan Description for full details.*

Out of Pocket Maximum includes Medical & Pharmacy: $5,000 per Individual (2x per Family)

Your new formulary can be found at ventegra.com. Select "Drug List & Formularies" at the bottom of the page, then download the Premium formulary.

Lower cost options for certain brand/specialty are available by reaching out to Collaborative Care. Specialty drugs and certain other drugs require pre-authorization, which may also be automatically initiated when the pharmacy attempts to fill the drug for the first time.

All out-of-pocket costs track to your out of pocket maximum.

Ventegra®

Copays shown are for a 30-day supply. Mail order available through Costco Mail Order Pharmacy at 2x the retail copay for a 90 day supply.

COSTCO PHARMACY | Mail Order

PRESCRIPTIONS FOR HOME DELIVERY

Costco Mail Order Pharmacy Ordering Instructions

Online Ordering

Costco Mail Order Pharmacy provides an Online Ordering service. If you choose to utilize Online Ordering, it is helpful to be familiar with basic online purchasing processes and have frequent access to your email account. Most communication between you and Costco Mail Order Pharmacy will be through email. When using this service, all orders for new prescriptions must be initiated online at **pharmacy.costco.com**.

How do I set up an account online?

Visit **pharmacy.costco.com.** Click "Sign In/Register." Select Create account, and enter your email address and a password. Please note: Each patient (self, spouse, dependent(s), etc.), independent of whether or not they are covered by the plan, must have his or her own unique email address to create an online account. Enter all required information to set up your online patient account including information regarding drug allergies, medical conditions, brand/generic preferences, etc.

How do I order a new prescription using the Online Ordering service?

If you need to start your medication immediately or do not have enough to last you at least two weeks, request two prescriptions from your prescriber: One for an initial short-term supply of your maintenance medication that your local retail pharmacy can fill immediately, and a second for a 90-day supply, including refills that can be submitted to Costco Mail Order Pharmacy.

- Visit **pharmacy.costco.com**. Click the "New Prescriptions" link and follow the steps below:

1. Log in.
2. Provide prescription information, including physician name, drug name and shipping method.
3. Confirm your order and mail the prescription to the address provided.

- Costco Pharmacy will begin processing your order once this request and the original prescription is received at our facility.
- Costco Mail Order Pharmacy does not hold prescriptions. Please send only prescriptions to be ordered immediately. Once an order has been processed, it cannot be stopped. We cannot accept returns.

How do I order a refill using the Online Ordering service?

- **Phone:** Call 1-800-607-6861. Costco's 24-hour automated telephone system guides you through the refill ordering process. Be sure to have your prescription number available.

OR

- **Online:** Visit **pharmacy.costco.com**. Click the "Refill Prescriptions" link.

What form of payment may I use for Traditional Mail Order service?

For your convenience and to make quick and secure payments, Costco accepts Visa®, MasterCard, Discover and Costco Credit Cards.

Frequently Asked Questions

When do I need to place my order?

It is Costco's goal to have your order in your hands 14 days after Costco receives it at the processing facility. Allow a few extra days when placing an order for the first time and remember to calculate the amount of time it may take for your prescription(s) request to reach the facility. Once Costco receives your order it will leave the facility within one to four days. Costco offers free standard shipping. Expedited shipping options are available for an additional fee. If you do not receive your order in 14 days, contact Costco Mail Order Pharmacy at the toll-free number provided.

How can I ensure my order will not be delayed?

Please ensure you are providing Costco with a valid shipping address and valid payment information. Ensure your name, address and phone number are written legibly on all submitted documents including the original prescription(s). Your physician must provide complete directions for use. Costco cannot dispense an order without valid instructions; "use as directed" will not be accepted. Ensure your prescription is written for the maximum days supplied allowed by your plan (usually 90 days) and contains additional refills.

How will I know the cost of my prescription order?

It is your responsibility to know the co-pay(s) for your prescription order. For additional information, please contact your benefits provider.

When I receive my order, what will be included in the package?

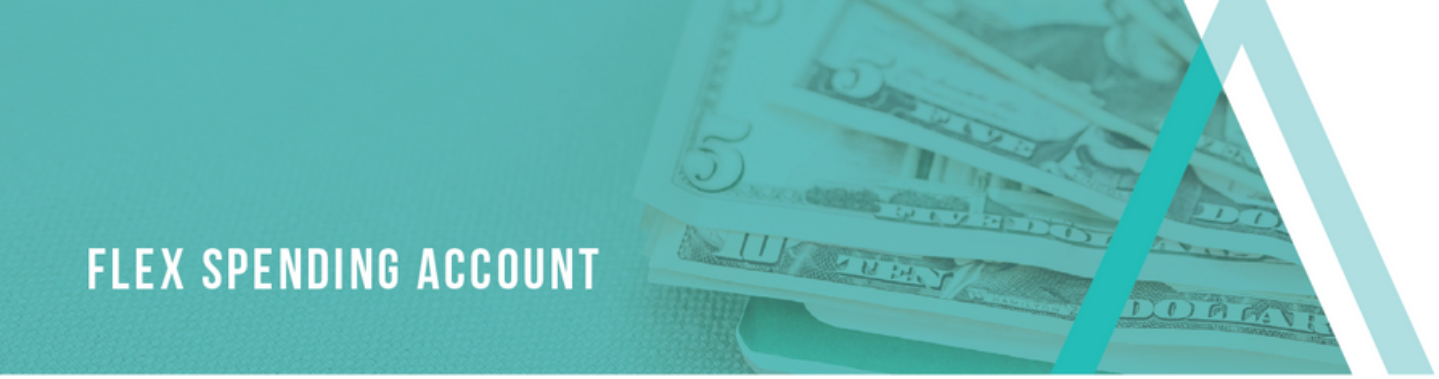
Each package will include your prescription medication, prescription label and a drug monograph. All prescription bottles will be sealed with child-safety caps to prevent them from opening during shipment. If you select easy-open caps, they will be included in the package for you to switch once your package has safely arrived.

Costco Mail Order Pharmacy Contact Information

Costco Mail Order Pharmacy Customer Service
1-800-607-6861 phone
1-800-633-0334 fax

Monday through Friday: 5 a.m. to 7 p.m. (PST) Saturday: 9:30 a.m. to 2 p.m. (PST)

Visit us online at:
pharmacy.costco.com



FLEX SPENDING ACCOUNT

Paying for health care can be stressful. That's why you're offered an employer-sponsored FSA. The Flexible Spending Account benefits offer reimbursement of specific expense types from money deducted from your earnings on a pre-tax basis. An annual election is required to participate in this program.

What Are the Benefits of an FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money**. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. Up to $660 can be rolled into the next year. Anything over that you will lose. You should only contribute the amount of money you expect to pay out of pocket that year. **The maximum amount you may contribute each year to an FSA is $3,300 per year. Note: Even if you signed up last year, you must re-enroll each year.**

What Is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

Can I Contribute to BOTH an HSA and a FLEX Account?

If you are contributing to an HSA account, you CANNOT contribute to a Health FLEX account. However, you CAN contribute to both an HSA and a Dependent Care FSA account.

How do I get reimbursed?

Please save your receipts and other supporting documentation related to your HC FSA expenses and claims. Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.

FSA Eligible Expenses

- Medical
- Dental
- Vision
- Pharmacy
- Durable Medical Equipment

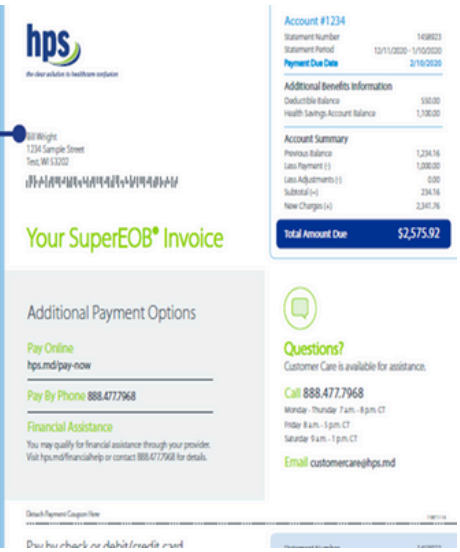
DCFSA Eligible Expenses

- After school program
- Before or after school program
- Child care
- Adult day care
- Elder care
- Nursery school
- Sick child care
- Transportation to and from eligible care

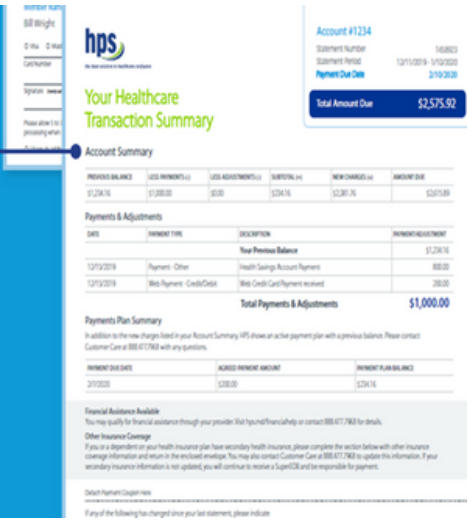
This is an example of eligible expenses. It is not a comprehensive list

SAMPLE EOB & ID CARD

The front page of your SuperEOB summarizes key information about managing your family's healthcare billing.



The additional pages of your SuperEOB provide an in-depth account of the claims you received within the last month.



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THREE WAVES

HEALTH CLINIC & WELLNESS CENTER

GENERAL INFORMATION & FAQ
Oshkosh Area School District

Three Waves Health Clinic & Wellness Center

Powered by Premise Health.

THREE WAVES HEALTH CLINIC & WELLNESS CENTER

Three Waves Health Clinic & Wellness Center is a joint partnership between the City of Oshkosh, Oshkosh Area School District, and Winnebago County to enhance the level of healthcare provided to employees and their family members. Our partner in providing health and wellness services is Premise Health.

The Three Waves Health Clinic & Wellness Center is available to any City of Oshkosh, Oshkosh Area School District, and Winnebago County employees, spouses, and dependent children, aged 24 months and up, enrolled in the medical plan.

In this document you will learn about the provider Care Coordinator and the services available along with frequently asked questions surrounding the health and wellness benefits available to you.

THREE WAVES

HEALTH CLINIC & WELLNESS CENTER

292 Ohio Street Oshkosh,
WI 54902

P: 920.267.5332

F: 920.267.5287

Monday-Thursday 7:00AM - 6:00PM

Friday 7:00AM - 12:00PM*

*Hours Subject to Change

CLINIC BENEFITS AND SERVICES

We want the Three Waves Health Clinic & Wellness Center to be the top choice for you and your family's primary, preventative and acute care needs. Our high quality providers can offer you the time and attention your health deserves. They can help manage your general primary care plus most urgent care needs. Additionally, the clinic providers can provide support and care for a variety of chronic conditions. While we are not a walk-in clinic, we will do our best to accommodate same day or next day appointments whenever possible.

Personal Health-Care That's Different

Affordable:

- No cost to eligible members

Convenient:

- Easy scheduling-online, phone app, telephone
- Convenient location
- Minimal wait times
- Same or next day appointments may be available
- Virtual health visits during and after hours
- Secure messaging with Care Coordinator available

Quality:

- More dedicated time with the provider
- Appointments are not double booked so the provider can focus solely on you and your needs for an extended amount of time

Private & Secure:

- Operated by a third party, Premise Health
- Your personal health records are confidential and private, protected by HIPPA

Personal Health		

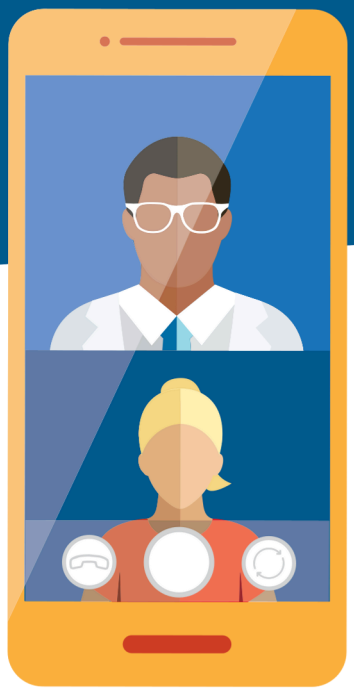
Preventive Care
• Routine wellness exams
Acute Illness
• Allergy care
• Cold, flu, etc.
• Headaches
• Infections (bacterial, ear, eye, sinus, urinary tract, viral, etc.)
• Rashes and skin conditions
• Sore throat
Minor Injuries / Procedures
• Mole removals
• Muscle and joint pain
• Sprains and strains
Coordination with Outside Providers
Referral to Specialists
	Lab Work & Vaccinations
	• Routine vaccinations
	• Order, conduct, interpret and consult on routine diagnostic lab work, including, but not limited to:
	  • Blood sugar
	  • Cholesterol
	  • Complete blood count
	  • COVID-19 testing
	  • Flu testing
	  • Pregnancy testing
	  • Preventive labs
	  • Strep throat testing
	  • Triglycerides
	  • Thyroid
	  • Urinalysis
	• Can complete lab draw with orders from outside provider
		Physical Therapy
		Medication Management
		• Prescribe medication, after thorough assessment
		• Onsite Pre-Packaged RXs
		Chronic Condition Management
		• Anxiety / depression
		• Asthma
		• Blood pressure
		• Cholesterol
		• Diabetes
		Care Coordination
		24/7 Virtual Primary Care
		Wellness Programing
		• Onsite Wellness Coach

HEALTH COACHING

Coaching conversations inspire and challenge you to go beyond what you can do alone. Coaching is a FREE resource for all plan member employees, spouses and dependents. The Three Waves Clinic Health Coach can be a guide, ally and accountability partner by helping you to create new healthy habits, let go of unhealthy behaviors, and in general, work with you to transform health goals into realities. Your first session will be a general introduction to coaching and an opportunity for you and the coach to discuss what health and wellness issues are important to you. Here are a few ideas to get the conversation started:

Sessions are held at your pace and are approximately 15 minutes to 1 hour length. Your RN Care Manager is onsite at the Health Center for face-to-face sessions but can also accommodate telephonic and virtual appointments. To schedule an appointment simply call Three Waves at 920-267-5332.

Primary care has gone virtual.



With virtual primary care through Premise Health, you can see a dedicated provider by phone or video. It's a convenient way to get the ongoing care you need on your terms with someone you trust.

Unlike traditional telemedicine, your provider will develop an understanding of your medical history, so there is no need to repeat your health information every visit.

How it's different:

- Virtual access to your primary care provider (PCP) at **NO COST** to eligible members
- A personalized treatment approach with a focus on prevention
- A wide range of services available at home or on the go

Primary care around the clock

Through this service, you also have on-demand access to a Team of providers who are available 24/7, so you can get the care you need, when and where you need it.

Make an appointment.

My Premise Health app

mypremisehealth.com

Sign in to MyPremisehealth.com and select "Get Care Now"

Who can use these services?

All members currently on the Winnebago County, Oshkosh Area School District, or City of Oshkosh health plan.

Three Waves Health Clinic & Wellness Center

Powered by Premise Health.

GENERAL CLINIC FAQ

Q.What is an employer-sponsored clinic?

A.An employer-sponsored clinic exclusively serves the employees, spouses and dependents of a specified company or organization for their primary and preventative health care needs. Clinic services are available at no cost to the health plan members of the City of Oshkosh, Winnebago County and the Oshkosh Area School District. By visiting The Three Waves Clinic, employees have access to primary and preventative care services that are both cost effective and convenient.

Q.What types of services are available at the clinic?

A.The Health Center is available for primary, preventative health and acute care needs including, but not limited to:

- Annual physicals
- Well-child exams (ages 2 and up)
- Management of chronic conditions
- diabetes
- hyperlipidemia
- hypertension
- asthma
- Sick visits
- Strep throat
- Upper respiratory infections
- Sinus and ear infections Minor
- injuries
- Sprains/strains
- Rashes
- Minor burns
- Immunizations and lab work
- Physical Therapy
- Muscle, bone, and joint pain
- Physical and Sports injuries
- Balance and Dizziness

The Health Center providers will evaluate and treat based on the reason for the visit. The Three Waves Health Clinic & Wellness Center providers can even serve as your primary care provider.

Q. Does the clinic offer health coaching services?

A. Yes, The health center offers a variety of health coaching services, with our RN Care Manger, such as, 1-on-1 onsite and telephonic coaching including: nutrition, weight loss, exercise, & stress management, disease management, nicotine cessation, small group coaching.

GENERAL CLINIC FAQ

Q.How do I make an appointment?

A.Appointments can be made by calling the clinic at 920.267.5332. Online booking is also available by logging into www.mypremisehealth.com or via the "MyPremisehealth" app on your mobile phone. To gain access to the online portal, contact the clinic and they will assist you with the process. The staff will do their best to offer same day appointments, but it is always best to call ahead.

Q.What is the cost of a visit to the clinic?

A.There is no cost to the patient for any treatment given by the provider during a visit including the office visit, lab work, immunizations and any other services performed at the Health Center.

Q.Can I come to the clinic for an emergency?

A.No. In the event of an emergency, call 911 immediately. The clinic is not structured to treat emergency situations.

Q.What if I need to see a specialist?

A.The providers will work with each patient to refer them to the appropriate specialist based on needs, preference, insurance plan and location. Like all services at the clinic, this is at no cost to the patient. Fees when visiting the specialist outside of the clinic will be subject to the terms of your health insurance plan.

Q.Is there x-ray onsite?

A.Patients are referred to a local imaging provider for this service. Fees for x-ray services are subject to the terms of your health insurance plan.

Q.Is there a lab onsite?

A.Yes, a full-service laboratory and point of care testing is available within the clinic for acute care, primary care and prevention visits. Examples may include strep and pregnancy testing, chemistry panels, CBC, lipid panel, glucose, PSA, TSH, etc.

Q.If I have a standing order to have labs drawn with my primary physician, can I complete these labs at the clinic?

A.After an establish-care visit with the Three Waves Health Clinic & Wellness Center, we are happy to draw and process labs for outside providers. However, because of the potentially critical or unique nature of some results, there may be certain lab work that is still best if drawn and processed at a specialty facility. We invite you to call ahead to discuss any questions about your needs.

GENERAL CLINIC FAQ

Q.What happens if my child develops an ear infection in the middle of the night?

A.The clinic opens at 7:00 am and the staff will make every effort to accommodate same day appointments for urgent care needs. If booking online after hours, please note the appointment will not be seen or approved until the clinic opens.

Q.What are the advantages for plan members using the clinic?

A.Advantages to patients who utilize the near-site clinic include no-cost quality healthcare, increased patient time and rapport with providers individualized care plans, low or no-wait time to see the provider, convenient clinic location and access, and same day appointments when available.

Q.Do I need to make an appointment?

A.Yes, we ask that patients schedule appointments; however, same-day appointments are typically available for urgent care needs.

Q.Is there a minimum age for clinic patients?

A.We are happy to see patients age two years and older at the Three Waves Health Clinic & Wellness Center.

Q.If I am a current patient of the clinic and working with a provider, can I call to obtain a prescription without scheduling an appointment?

A.We can refill prescriptions for ongoing or chronic issues without a visit but would require a visit for acute or new complaints. The clinic staff will handle each request on a case-by-case basis.

Q.How do you share records with a person's primary care physician?

A.With the appropriate authorization from the patient, providers may collaborate with other care providers and share medical records electronically, via paper or secure fax.

MEDICATION FORMULARY FAQ

Q.How were our formulary medications chosen?

A.The medications dispensed by the clinic are those that are most utilized by employees based off data from the company's health plan. The medications were narrowed to include both acute and chronic conditions and covering a broad spectrum of conditions.

Q.The medication I take is not on our formulary. Is there an option to add medications to this list?

A.No, however, modifications to the formulary list are made regularly based off general prescribing and dispensing trends in the clinic.

Q.Can I bring a prescription from an outside provider to fill at the Three Waves Health Clinic & Wellness Center?

A.While we are happy to work in coordinating care with your current provider(s), the use of our clinic's prescription formulary service is limited to medications prescribed at the Three Waves Health Clinic & Wellness Center. If you wish to use the formulary, please set up an appointment with one of our providers so that we may thoroughly review your medical history.

Q.If I receive a prescription from a provider at the clinic, will I still be able to fill my prescriptions at my pharmacy?

A.Yes, you will always have the option of filling prescriptions at your pharmacy. The clinic's formulary is an added benefit to current patients, providing a no-cost option for certain medications that also save your health plan money. Should you choose to have a prescription filled outside the clinic formulary, co-pays would apply as defined by your health insurance plan.

Q.Will there be a charge for prescriptions dispensed at the clinic and can I refill my prescription at the clinic?

A.All medication is at no cost to the patient and can be refilled at the clinic.

Q.Will dispensed prescriptions be applied to my deductible?

A.No, as there is no patient fee for medications dispensed by the clinic, no amount will be applied to the patient's health plan deductible.

MEDICATIONS OFFERED

MEDICATION	PILL COUNT	FORM	STRENGTH
Amlodipine Besylate	90	TAB	10 MG
Amoxicillin (BID)	20	TAB	875 MG
Amoxicillin/Clavulanate Potassium	20	TAB	875 MG
Atorvastatin Calcium	90	TAB	20 MG
Azithromycin		TAB	250 MG
Cephalexin	30	CAP	500 MG
Ciprofloxacin	20	TAB	500 MG
CitalopramHBr	90	TAB	20 MG
Doxycycline Monohydrate	20	CAP	100 MG
Erythromycin	n/a	CREAM	3.5 GM
Fluconazole		TAB	150 MG
Guaifenesin/Dextromethorphan Syrup	n/a	SYRUP	4 OZ
Lisinopril	90	TAB	20 MG
Lisinopril-Hydrochlorothiazide	90	TAB	20 - 25 MG
Losartan Potassium	90	TAB	50 MG
Metformin HCL	90	TAB	500 MG
Metoprolol Tartrate	90	TAB	50 MG
Metronidazole	14	TAB	500 MG
Omeprazole	90	CAP	40 MG
Omeprazole	90	CAP	20 MG
Ondansetron	10	TAB	4 MG
Prednisone	10	TAB	20 MG
Sertraline HCL	90	TAB	50 MG
Simvastatin	90	TAB	20 MG
Simvastatin	90	TAB	40 MG
Sulfamethoxazole/Trimethoprim	10	TAB	800/1600 MG
Sumatriptan Succinate		TAB	50 MG

Please Note: This is a separate service from your pharmacy benefit through your health plan. Your health plan or pharmacy benefit manager (PBM) cannot assist you with questions regarding medications dispensed at the clinic.

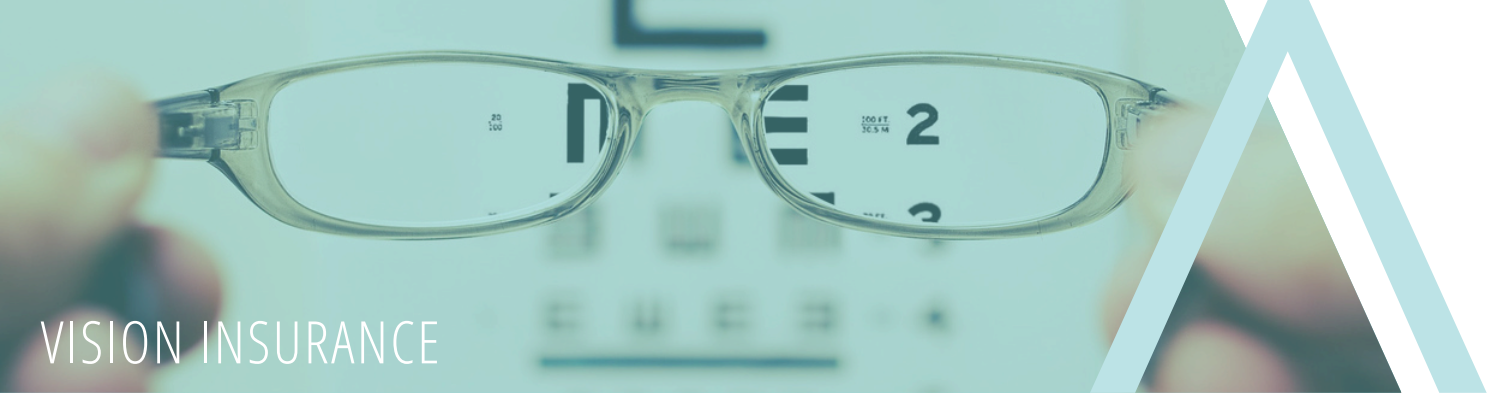
DENTAL INSURANCE

PLAN COVERAGE	DELTA PPO	DELTA PREMIER	NON-CONTRACTED
Deductible (Individual/Family)	$50 | $150	$50 | $150	$100 | $300
Annual Maximum	$1500	$1000	$500
Preventative (Cleaning, X-rays, Exams, Sealants	100%	100%	50%
Basic Services	80%	80%	40%
Major Services	50%	50%	40%
Orthodontia Services	50%	50%	Not Covered
Orthodontia Lifetime Maximum	$2000	$2000	Not Covered

DENTAL EMPLOYEE CONTRIBUTIONS PER PAYROLL

Employee Only	$2.14
Family	$6.99

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



VISION INSURANCE

PLAN COVERAGE	MEMBER COST In Network	MEMBER COST Out of Network
Exams	$0 Copay	$35 Reimbursement
Frames*	$150 Allowance, then 20% off Balance	$75 Reimbursement
Lenses: Single Bifocal Trifocal	Covered in Full	$25 Reimbursement $40 Reimbursement $55 Reimbursement
Contacts*: Elective Medically Necessary	$150 Allowance Covered in Full	$120 Reimbursement $200 Reimbursement

*$150 max allowance per year for frames OR contacts

VISION EMPLOYEE CONTRIBUTIONS PER PAYROLL

Employee Only	$4.77
Family	$11.88

LIFE & ADD INSURANCE

VOYA FINANCIAL™

Teachers and Administrators

Life insurance can help provide for your loved ones if something were to happen to you. Your employer provides a company-paid Life and AD&D policy for all full-time employees.

BASIC TERM LIFE & AD&D - EMPLOYER PAID	
Amount of Benefit	1x Annual Compensation up to $200,000

Voluntary Supplemental Life and ADD is available for you your spouse or domestic partner and your dependents

VOLUNTARY TERM LIFE & AD&D - EMPLOYEE PAID	
Benefit Increments	$10,000 per Employee $10,000 per Spouse $2,000 per Child
Guaranteed Issue Amount	$150,000 per Employee $50,000 per Spouse $10,000 per Child
Benefit Maximum	$500,000 per Employee $250,000 per Spouse $2,000 to $10,000 per Child

Note: if you elect more than the guaranteed issue amounts, you will need to complete an Evidence of Insurability process.
For rates and additional details, see Carrier Materials

LIFE & ADD INSURANCE

Food Services, Clerical, Custodians and Para

The Basic Term Life Insurance Plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. This benefit is paid for by Oshkosh Area School District and includes:

BASIC TERM LIFE & AD&D - EMPLOYER PAID	
Amount of Benefit	1x Previous Year's Earnings

You can elect Supplemental and Additional Term Life Insurance coverage for yourself above the basic coverage. This coverage is paid for by you.

VOLUNTARY TERM LIFE & AD&D - EMPLOYEE PAID	
Supplemental Term Life	1x Previous Year's Earnings per Employee
Additional Term Life	1x, 2x, or 3x Previous Year's Earnings per Employee

Note: if you elect more than the guaranteed issue amounts, you will need to complete an Evidence of Insurability process.

For rates and additional details, see Carrier Materials

SHORT TERM AND LONG TERM DISABILITY

Your employer provides short-term and long term disability coverage for all full time eligible employees, which pays a percentage of your salary if you become temporarily disabled; meaning you're not able to work for a short period of time due to sickness or injury not related to your job. You are not eligible to receive disability benefits if you are receiving worker's compensation benefits.

SHORT-TERM DISABILITY- EMPLOYEE PAID*	BENEFIT
Elimination Period	8 days for accident 8 days for sickness
Weekly Benefit	66 2/3%
Maximum Weekly Benefit	$1,000
Benefit Duration	12 Weeks
Earnings Definition	Annual Salary

*Pre-Existing Condition Limitation: 6/12 (If member sees a doctor for a condition within 6 months of plan start and becomes disabled due to that condition within 12 months of plan start, the policy will not be payable.
*Offsets: Your benefit may be reduced by other income sources such as, (not limited to), Social Security, Workers Comp, etc.

LONG-TERM DISABILITY- EMPLOYER PAID	BENEFIT
Elimination Period	90 Days
Benefit Percentage	90%
Maximum Monthly Benefit	$9,000

*Pre-Existing Condition Limitation: 3/12 (If member sees a doctor for a condition within 3 months of plan start and becomes disabled due to that condition within 12 months of plan start, the policy will not be payable.

Plan Highlights

Voluntary Group Accident Insurance

Oshkosh Area School District

COVERAGE

Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

ELIGIBILITY

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse or domestic partner. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

BENEFIT AMOUNT

See Full Schedule of Benefits on next page

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

MONTHLY PREMIUM

Coverage	Premium
Employee	$ 9.75
Employee and Spouse	$ 15.90
Employee & Children	$ 21.50
Employee & Family	$ 27.87

FEATURES

- Portability to Employee Age 70
- FMLA/MSLA Continuation
- Newlywed and Newborn Provision
- 24-Hour Travel Assistance Services
- Off the Job Coverage

RELIANCE STANDARD
LIFE INSURANCE COMPANY

www.reliancestandard.com

Benefits	Amount
Ambulance	$150 Ground, $750 Air
Blood, Plasma and Platelets	$200
Burns	To $1,200 for 2nd degree burns; To $9,600 for 3rd degree burns; Skin Graft - 50% of benefit payable for Burns
Chiropractic Services (per Visit)	$25 per session, 6 sessions maximum
Coma	$7,500
Concussion	$150
Dental Injury	$225 for Crown; $75 for Extraction
Diagnostic Exams	$100 per CT/MRI scan
Dislocation	To $3,200 for Non-surgical; To $6,400 for Surgical; Partial - 25% of full dislocation; Multiple - 100% of highest dislocation benefit
Emergency Treatment	$225
Epidural Anesthesia Injection (per Injection)	$50, 2 maximum
Eye Injury	$150 for removal of foreign object, $300 for surgical repair
Fractures	500 for Non-surgical; To $15,000 for Surgical repair; Chip fracture: 25% of non□surgical benefit; Multiple fractures: 200% of highest sustained fracture
Initial Hospital Admission	$1,000
Hospital Confinement (per Day)	$150, 365 days maximum
Intensive Care Unit (ICU) Confinement (per Day)	$240, 30 days maximum
Lodging (per Day)	$100 per day up to 30 days if more than 100 miles from residence
Medical Appliances	$150
Organized Youth Sports Benefit	25% of the benefit amount
Paralysis	$15,000 quadriplegia; $7,500 paraplegia/hemiplegia
Physical Therapy (per Session)	$50, 10 sessions maximum
Physician Visit	$100 Initial, $100 Follow-up
Prosthesis	$500 for one, $1,000 for two or more
Rehabilitation Facility Confinement (per Day)	$50, 30 days maximum
Surgery	$150 for Exploratory; $450 for Knee Cartilage; $1,500 for Abdominal or Thoracic; $750 for Ruptured Disc; to $900 Tendon, Ligament, or Rotator cuff
Transportation	$300, if more than 100 miles from residence
X-Rays	$50
Wellness (Health Screening) Benefit	Amount
Wellness (Health Screening)	$50

Plan Highlights

Voluntary Group Hospital Indemnity Insurance

Oshkosh Area School District

COVERAGE

Voluntary hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

ELIGIBILITY

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered. Dependents are:

- Your legal spouse or domestic partner. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.

FEATURES

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions
- No deductibles

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

BENEFITS

Hospital Room & Board Benefits	
Room & Board Benefit per Day (365 Daily Benefits per Coverage Year)*	$100
Hospital Critical Care Unit Benefits	
Critical Care Unit Benefits per Day (30 Daily Benefits per Coverage Year)	$200
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Hospital Critical Care Admission Benefi	
One Daily Benefit per Coverage Year	$1,000

**In no event will the Daily Benefits exceed 365 daily benefits per Coverage Year.*

MONTHLY PREMIUM

Coverage	Premium
Employee	$ 15.15
Employee & Spouse	$ 26.50
Employee & Child(ren)	$ 22.25
Employee & Family	$ 32.97

RELIANCE STANDARD
LIFE INSURANCE COMPANY

www.reliancestandard.com

EMPLOYEE ASSISTANCE PROGRAM

At any given time, 70 percent of employees say their productivity is impacted by stress, anxiety and personal issues.

Through the Employee Assistance Program, employees are able to better manage their stress, anxiety and other issues which impact quality of life.

The Employee Assistance Program through Ascension is available to all employees and paid for by your employer.

The employee is able to receive up to 8 sessions per issue. Example: One issue may be financial difficulty. Another issue might be a family crisis. Yet a third might relate to substance concerns or abuse. The employee can use 8 EAP sessions per issue.

This benefit extends beyond the employee to include the spouse and dependents in their immediate household.

All appointments are absolutely confidential. Your employer does not know if you have used any EAP services.

ASCENSION

800-540-3758

eap@ascension.org

ascensionWIEAP.org

Life Transitions

Personalized guidance to find the best health insurance cost and coverage options

- Retirement (due to age or disability)
- Medicare age
- Disability (new or existing)
- COBRA (due to plan termination)
- Not eligible for employer benefits
- Children 18 and under (eligibility due to income guidelines)
- Pregnancy
- Adult dependents ages 18 to 26
- Adults transitioning off parent's plan

Part of your health plan

Free unbiased resource

No obligation to change coverage

No pressure

How it Works

01. **Submit Online Request:** Avergent.com/lifetransitions

Call: 866-247-5415

02. Schedule a consultation

03. Come away with peace of mind

AVERGENT

IMPORTANT NOTICES

This Benefit Guide provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern. The employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Benefit Guide is not a contract, and participation in any of the plans does not guarantee employment.

IMPORTANT NOTICES

MICHELLE'S LAW

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence.
When Michelle's Law was enacted,many health insurance plans required adult children to have full-time student status to be eligible for dependent coverage. However, due to the Affordable Care Act's (ACA) reforms, most grouphealth plans no longer imposea full-time studentstatus requirement for dependent eligibility.
Under the ACA, group healthplans or insurersthat provide coverage for dependent childrenmust continue to make coverage available until a child attains age 26, regardless of student status. Thus, Michelle's Law will generally apply only to health plans that provide coverage to dependent full-time students who are age 26 or older.

Coverage Requirements
Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.
Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
• All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and
• Treatment of physical complications of the mastectomy, including lymphedema.
These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

Annual Notice
Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at for more information

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

We are committed to the privacy of your health organization. The administrators of the medical plans use strict privacy standards to protect your health information from unauthorized use or disclosure. The plan's policies protecting your privacy rights and your rights under the law are described in the plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage
If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption
If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

• The birth of a child or placement of a child for adoption or foster care;
• To bond with a child (leave must be taken within one year of the child's birth or placement);
• To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
• For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
• For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.
An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.
An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.
Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS. While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.
Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.
An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:
• Have worked for the employer for at least 12 months;
• Have at least 1,250 hours of service in the 12 months before taking leave;* and
• Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.
Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.
Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.
Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights

General Notice of COBRA Continuation Coverage Rights

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Kathy Jurgensmier
Benefits Manager
920.424.0163
kathryn.jurgensmier@oshkosh.k12.wi.us

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period0F to sign up for Medicare Part A or B, beginning on the earlier of
- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.
Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Plan contact information

Kathy Jurgensmier
Benefits Manager
920.424.0163
kathryn.jurgensmier@oshkosh.k12.wi.us

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)