KIEL

AREA SCHOOL DISTRICT

2025 BENEFITS GUIDE

7/1/2025 – 6/30/2026 Benefits

TABLE OF CONTENTS

CARRIER CONTACTS

COVERAGE	CARRIER	CONTACT
Medical	UMR	800.207.3172 www.umr.com
FSA	EBC	608.831.8445 www.ebcflex.com
Dental	Delta Dental	800.236.3712 www.deltadentalwi.com
Vision	Delta Vision	800.236.3712 www.deltadentalwi.com
Group Long-Term Disability	The Standard	888.937.4783 www.standard.com
Group Short Term Disability ***NEW**	The Standard	888.937.4783 www.standard.com
Group Life and AD&D	The Standard	888.937.4783 www.standard.com
Voluntary Life and AD&D	The Standard	888.937.4783 www.standard.com
Employee Assistance Program	Aurora	800.236.3231 www.aurora.org/eap

MEDICAL PLAN

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family.

Your medical plan is administered by UMR, with access to the UnitedHealthcare Choice Plus network.

The High Deductible Health Plan offered to eligible employees of Kiel Area School District has access to a Health Savings Account (HSA) that can be used to save pre-tax dollars to pay for health care expenses.

You generally pay less when you receive care from doctors, hospitals and other health care facilities that participate in the UnitedHealthcare Choice Plus network. Find a participating health care provider in your area by going to: UMR.com > Find a Provider > and searching for the United Healthcare Choice Plus network.

Refer to the Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) for detailed medical plan coverage information.

ELIGIBILITY

- Full-time employees working at least 30 hours per week

AND THEIR:

- Spouses
- Biological children, stepchildren, legally adopted children (effective from the date placed for adoption), and foster children up to age 26

TERMS TO KNOW

DEDUCTIBLE

The amount ***you pay*** out of your pocket each year ***before the plan begins*** sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

OUT-OF-POCKET MAXIMUM (OOPM)

The most you'll have to pay out of your pocket in a calendar year for covered services.

COINSURANCE

The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan up to the OOPM. The plan covers the percentage of the expense shown.

IN-NETWORK / OUT-OF-NETWORK COINSURANCE

PLAN PAYS 100% | PLAN PAYS 70%

YOU PAY 0% | YOU PAY 30%

MEDICAL PLAN HIGHLIGHTS

UMR CHOICE PLUS NETWORK	$1,800 / $3,600 DEDUCTIBLE HDHP IN-NETWORK	 OUT-OF-NETWORK
DEDUCTIBLE		
Single Family	$1,800 $3,600	$3,600 $7,200
OUT-OF-POCKET MAXIMUM		
Single Family	$4,000 $8,000	$6,000 $12,000
Coinsurance	90%	70%
PHYSICIAN SERVICES		
Select Preventive Care	Covered in Full	Deductible & Coinsurance
Teladoc General Medicine Teladoc Dermatology Teladoc Behavioral Health	$54 or Less $85 or Less Therapist: $95 or Less Psychiatrist: $235 or Less	Not Applicable Not Applicable Not Applicable
Primary Care Physician Specialist	Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance
HOSPITAL SERVICES		
Inpatient / Outpatient	Deductible & Coinsurance	Deductible & Coinsurance
URGENT & EMERGENCY CARE		
Urgent Care	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care	Deductible & Coinsurance	Deductible & Coinsurance
PRESCRIPTION DRUGS	Deductible & Coinsurance	Deductible & Coinsurance

Refer to the Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) for detailed medical plan coverage information.

MONTHLY RATES	EMPLOYER COST	EMPLOYEE COST
Employee	$779.99	$111.44
Family	$2,087.75	$298.26

Rates vary by class

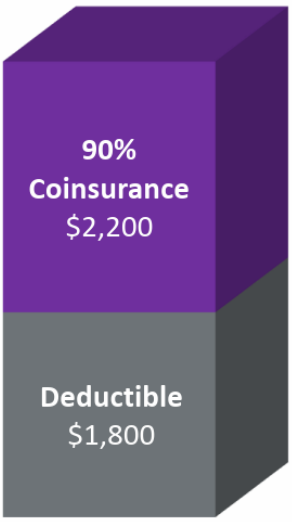
Cash in Lieu of Health Coverage

- The district will pay cash in the amount of $125 per pay period to Teachers/Managerial who waive the health insurance and provide proof of employer-sponsored medical coverage.
- The district will pay cash in the amount of $437.50 per quarter to Support Staff who waive the health insurance and provide proof of employer-sponsored medical coverage.
- The district will pay cash in the amount of $62.50 per pay period to Administrative Support who waive the health insurance and provide proof of employer-sponsored medical coverage

Maximum Out-of-Pocket Model

Single Plan Illustration

- 90% Coinsurance after Deductible
- Maximum Out of Pocket of $4,000 *(in-network)*



NEXT $22,000 in Claims

- Member pays $2,200
- Plan pays $19,800

FIRST $1,800 in Claims

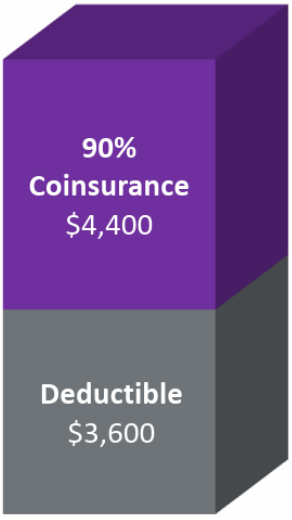
- Member pays $1,800
- Plan pays $0

Maximum Out of Pocket of $4,000 is Reached (***$1,800*** *is the deductible,* ***$2,200*** *is coinsurance)*

**HSA dollars can also be used towards the out-of-pocket costs. The HSA contribution limit for 2025 is $4,300 for single coverage.*

Family Plan Illustration

- 90% Coinsurance after Deductible
- Maximum Out of Pocket of $8,000 *(in-network)*



NEXT $44,000 in Claims

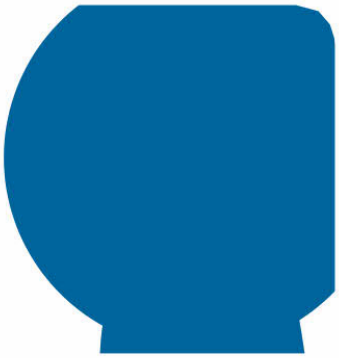
- Member pays $4,400
- Plan pays $39,600

FIRST $3,600 in Claims

- Member pays $3,600
- Plan pays $0

Maximum Out of Pocket of $8,000 is Reached (***$3,600*** *is the deductible,* ***$4,400*** *is coinsurance)*

**HSA dollars can also be used towards the out-of-pocket costs. The HSA contribution limit for 2025 is $8,550 for family coverage.*



Health care in the modern world calls for a sensitive, personal approach to service – one that's built on real relationships and trust.

Which is why Plan Advisor delivers an experience that's beyond traditional models of member support. Our advisors partner with you so you feel more confident in the decisions you make about your health, and comforted by the steps you're taking to get there.

Because we all need a person we can rely on.
Let your Plan Advisor be yours.

Connecting you to the care you need

Whether your question is common or complex, we make it easier for you to get answers by ensuring you have the information you need.

Keeping it real

Your plan advisor is an actual person who's focused on serving you, equipped with knowledge and options to support and anticipate your unique needs and goals.

We're in it with you

If you need something that's out of our reach, we'll connect you to the resources your need – and we'll even stay on the call as long as you need.

Dedicated to YOU

To connect with your Plan Advisor, call the number on the back of your member ID card.

Plan Advisor
Your personal guide to all things health care

VISIT US ANYTIME ONLINE AT UMR.COM

Sign up for online services and get quick and easy access to your claims and benefit information.

With **umr.com**, you can:

- Look up network providers
- Check your claims activity
- Review your financial activity
- Find tools for improving your health

You can even log in on the go with your smart phone or mobile device.

We're ready when you are

Here are some of the ways we can help:

Finding the right fit is important. We can help

Finding the right provider can feel daunting. We'll match you to high-quality health care providers and the highest level of benefits – right where you live – to avoid paying more than you need to. We can schedule appointments with providers, and identify possible health screenings or preventive care.

Know your coverage – and costs

Navigating health care can be tricky, which is why no question is a bad one. Your plan advisor is ready to go over your benefit details with you, or connect you to the right person to find the answer you need, so you won't be caught by surprise.

We'll help you:

- Look into a recent medical claim to make sure it was paid correctly
- Check to see what your out-of-pocket costs are for services
- See how much you have paid – and how much you have left – of your individual or family deductible
- Understand reward programs available to you
- Discover what services are available to you based on your plan

Let's talk

Our plan advisors are available weekdays from 7a.m. to 5 p.m. Central time at 800-207-3172.

UMR

A UnitedHealthcare Company

You've got Teladoc Health

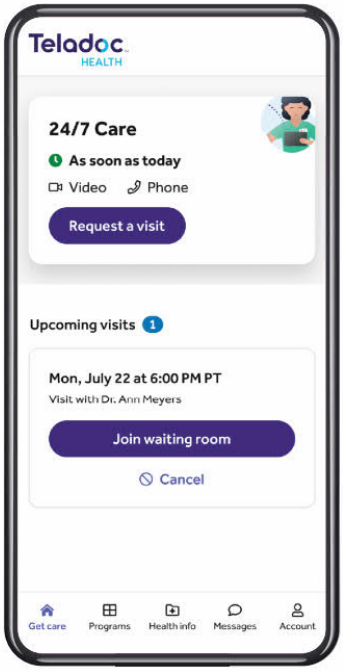
Teladoc HEALTH

Access to quality care when you need it most

General Medical (24/7 Care) | $54 or less/visit
Talk to a licensed healthcare provider for non-urgent conditions 24/7.
Flu • Sinus infections • Sore throats • And more

Mental Health
Talk to the therapist who's right for you by phone or video.
$95 or less/therapist visit
$235 or less/psychiatrist first visit
$105 or less/psychiatrist ongoing visit

Dermatology | $85 or less/online review
Upload images of your skin issue online and get a custom treatment plan within 24 hours.



Register or log in today

Visit Teladoc.com
Call 1-800-TELADOC (800-835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

Mental Health care is available for eligible members ages 18-plus.
Phone and video visits are not required or part of the dermatology visit.

172346

TM-GM-10E-C24-02_411295158_12042019

Remember to call ahead

A UnitedHealthcare Company

Make sure you're covered before receiving care

Any time you or a family member is planning to be admitted to the hospital or get certain outpatient services, it is important to let UMR know. We want to make sure you receive the appropriate care and that you understand whether your benefit plan will pay for any portion of the treatment cost.

You or your health care provider can call the number on the back of your health ID card to verify your benefits. Our decisions are for payment purposes only. All decisions about the types of care you may receive are between you and your providers.

2 reasons you or your provider should call UMR before a medical service or procedure:

1 Request prior authorization

Some types of care require a review to determine if they are medically necessary. This means they meet generally accepted standards of care and are considered effective in treating your illness or injury. We also review if the length of your inpatient stay and type of facility are clinically appropriate. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.

2 Know before you go

We recommend you and your health care provider also call ahead regarding treatments that do not require a review. This is to verify the amount, if any, your health plan will pay toward the cost of care you plan to receive.

Any payment for an expense that is not covered under the plan is the patient's responsibility.

We will send a letter to you and your provider, notifying you whether the treatment is covered.

Procedures that are commonly reviewed[1]:

- Inpatient hospitalization and surgeries[2]
- Inpatient rehabilitation and behavioral health
- Skilled nursing facility
- Home health care
- Durable medical equipment
- Radiology services such as MRA, MRI, PET and CT scans
- Chemotherapy and radiation
- Dialysis
- Occupational, speech or physical therapy
- Transplants and transplant-related services
- Reconstructive surgeries and cosmetic procedures
- Clinical trials and experimental procedures
- Genetic testing
- Hormone therapies
- Specialty injectable drugs

[1] This list is not all-inclusive. Please refer to your summary plan description (SPD) for a full list of services requiring prior authorization. UMR pays providers according to the coverage terms, benefits, limitations and exclusions of your benefit plan documents.

[2] Except stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a cesarean section.

Understanding Your Care Options

Proactively understanding your care options can have a big impact in the amount you pay out-of-pocket when seeking care. The chart below is intended to help you identify the right setting for your specific needs.

Type of Care	Common Services		Approximate Wait Time	Average Member Cost
Teladoc 	○ Colds or flu ○ Bronchitis ○ Respiratory infection ○ Pink eye	○ Sinus problems ○ Allergies ○ Urinary tract infection Poison ivy	**15-20** Minutes	**$**
Your Doctor's Office 	○ Preventative services Vaccinations	○ Medical problems that are not an immediate, serious threat to your health or life	**1 Week** or More	**$$**
Urgent Care 	○ Sprains or strains ○ Mild asthma attack ○ Sore throat Earaches	○ Minor broken bone ○ Minor cut ○ Minor infection Minor rash	**20 – 30** Minutes	**$$$**
Emergency Room 	○ Sudden change in vision ○ Sudden trouble talking ○ Large open wounds ○ Major burn	○ Severe head injury ○ Heavy bleeding ○ Chest pain Major broken bone	**3 – 12** Hours	**$$$$**

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) allows you to pay for qualified medical expenses tax-free. For all health care-related accounts, eligibility is determined in part by which medical plan you choose.

HEALTH SAVINGS ACCOUNT (HSA)

Kiel Area School District offers a medical plan that features an HSA – the High Deductible Health Plan. An HSA is an investment tool available where the money you save goes in tax-free, earns interest tax free and can be spent on qualified health care expenses tax-free.

If you are enrolled in the High Deductible Health Plan option, you may open an HSA account with the bank or institution of your choice.

HOW THE HSA WORKS

MONEY GOES IN	Pretax contributions* from you, up to a total of: ○ $4,300 for individual coverage ○ $8,550 if you enroll your spouse and/or child(ren) ○ An extra $1,000 if you are age 55 or older You pay the full cost of non-preventive care, including non-preventive prescription drugs, until you meet the deductible. You receive discounted rates in-network.
MONEY GOES OUT	When you have an eligible health care expense, **you decide whether to use your HSA if you've accumulated enough money to cover it or pay with other resources. Either way, those dollars count toward the medical plans' deductible and out-of-pocket maximum. Any amount you spend on qualified medical expenses is also tax-free.
HAVE MONEY LEFT? **IT ROLLS OVER!**	Any money left in your account is yours to pay for health care in the future. There's no deadline and no limit on how large your account can grow. If you leave Kiel Area School District, you can take it with you.

* *If you're enrolling during the year, you may not be eligible to make a full-year contribution to your HSA. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 969 for more information.*

** *The HSA can be used to reimburse you for qualified medical, dental, and vision expenses. See IRS Publication 502 for more information.*

HSA ELIGIBILITY

○ You must be enrolled in a HDHP ○ You cannot have any other "impermissible coverage". If your spouse has a traditional health care FSA, you are not eligible to contribute to an HSA.	○ You cannot be currently enrolled in Medicare	○ You cannot be claimed as a dependent on another person's tax return

FLEXIBLE SPENDING ACCOUNTS (FSA)

With an FSA, you can set aside tax-free money to pay for eligible medical and dependent care expenses. When you participate in an FSA, you decide how much you want to contribute each plan year. The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!*** However, you must use the amounts in your account by year-end or lose the balance.

Kiel Area School District offers three types of FSAs administered by Employee Benefits Corporation (EBC).

TRADITIONAL HEALTH CARE FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. You're ***not*** eligible for the Traditional Health Care FSA if you are currently contributing to a Health Savings Account.

LIMITED HEALTH CARE FSA

The expenses that are reimbursed by this FSA are limited to dental and vision care expenses in the plan year only. You're eligible if you're enrolled in the High Deductible Health Plan; use the Limited Health Care FSA along with a Health Savings Account (HSA) and maximize your tax savings!

TRADITIONAL AND LIMITED FSA CONTRIBUTION LIMITS

Kiel Area School District follows the indexed contribution limits set for this type of account by the Internal Revenue Service (IRS). The contribution limits for both the Traditional Health Care FSA and Limited Health Care FSA work on an individual employee/financial representative basis. The individual maximum for 2025 is $3,300. However, if you and your spouse are both eligible for the same employer's FSA, you can each contribute separately to have your own $3,300 cap.

DEPENDENT CARE FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of $5,000 per year. Individuals who are married and file taxes separately can contribute up to a maximum of $2,500. You can't contribute more than you or your spouse earned in income for the year.

If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.

DENTAL

Healthy teeth and gums are an important part of maintaining your overall health. That's why Kiel Area School District offers a dental plan administered by Delta Dental of Wisconsin.

DELTA DENTAL	PREMIER & PPO
INDIVIDUAL ANNUAL MAXIMUM	**$1,000**
DEDUCTIBLE	
Employee Only	$0
Family	$0
PREVENTIVE SERVICES	
Exams, Cleanings, Fluoride Treatments	100%
X-Rays, Space Maintainers, Sealants	100%
Emergency Treatment to Relieve Pain	100%
BASIC RESTORATIVE SERVICES	
Fillings	100%
Endodontics & Periodontics	100%
Extractions	100%
Repairs & Adjustments to Bridges & Dentures	100%
MAJOR RESTORATIVE SERVICES	
Crowns, Inlays, Onlays	50%
Bridges and Dentures	50%
Implants	50%
ORTHODONTIC SERVICES	
Coinsurance to Individual Lifetime Maximum	50% to $800
Dependent Children to Age	19

MONTHLY RATES*	EMPLOYER COST	EMPLOYEE COST
Employee	$41.68	$0
Family	$124.52	$0

*Rates vary by class

Reminder:

- Your plan includes the Evidence Based Integrated Care Plan (EBICP). EBICP is an enhancement that provides expanded benefits for individuals with diseases and medical conditions that have oral health implications such as Periodontal Disease, Diabetes, Pregnancy, and more. See the plan document for further details.
- Your dental plan includes CheckUp Plus where the cost of diagnostic and preventive services does not count towards your annual maximum benefit. See the flyer on the next page for further information.

DELTA DENTAL®

Smarter Dental Plans

CheckUp Plus™

Our CheckUp Plus™ plan option allows enrollees to get diagnostic and preventive dental services without those costs getting applied to the individual annual maximum. Preventive care saves money over the long-term by reducing the need for more expensive services.

CheckUp Plus™ lets you keep your annual maximum for the things you need, not the things you deserve.

The charts show the impact of CheckUp Plus™ on an enrollee's individual annual maximum compared to a traditional plan. Example assumes two routine check-ups, covered at 100% and a $1,000 annual maximum.

	CheckUp Plus™	Traditional Dental Plan
Delta Dental Pays	$300	$300
Enrollee Pays	$0	$0
Maximum Remaining	$1,000	$700

Plan benefit and dentist charges vary.

Connect With Us

www.deltadentalwi.com

SS300F-2502

Vision Care Discount

A Vision Discount Program is included with your Delta Dental plan.

Delta Dental of Wisconsin has chosen EyeMed Vision Care® as the network provider for your vision care discount program. This is not insurance, but a discount plan that provides:

- Overall savings up to 35%.
- Access to thousands of private practice and retail providers nationwide.
- Choice of any product, including designer brand-name frames (certain brands impose a no-discount policy and the frame discount is not available).
- Savings on laser vision correction.
- Replacement contact lenses by mail.

accessing your benefits

Receiving your vision care discount is easy.

1. Locate an EyeMed Vision Care provider using the provider search on our website at **www.deltadentalwi.com/vision**. Choose the Access Network. Or call EyeMed at **866-246-9041** (toll-free).
2. When scheduling an appointment, inform the office that you have a vision discount plan through the EyeMed Access panel of providers.
3. When you arrive for your appointment, present the enrollee card below to receive services.

This is a discount plan. It is not insurance. This discount plan may not be combined with any other discounts, promotional offers, or insurance coverage, and does not apply to EyeMed provider's professional services, or contact lenses.

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Name:

For provider information, go to www.deltadentalwi.com/vision. Choose the Access network. Or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Name:

For provider information, go to www.deltadentalwi.com/vision. Choose the Access network. Or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

Vision Discount Program	Cost/Savings
Exam (with dilation as necessary)	$5 off comprehensive exam/ $5 off contact-lens exam
Complete Pair of Glasses The following discounts and fees for frames, lenses, and lens options apply only if a complete pair is purchased in the same transaction. Items purchased separately will be discounted 20% off of the retail price.	
Frames (any frame available at provider location)	35% off retail price
Single Plastic Lenses (including standard scratch coating)	Member Pays:
Single-Vision	$50
Bifocal	$70
Trifocal	$105
Lens Options	Member Pays:
UV Coating	$15
Tint (solid and gradient)	$15
Standard Polycarbonate	$40
Standard Anti-Reflective Coating	$45
Standard Progressive (add-on to bifocal)	$65
Conventional Contact Lenses (materials only)	15% off retail price
Laser Vision Correction (LASIK or PRK)	15% off retail price or 5% off promotional price
Frequency (exams, frames, lenses, and contact lenses)	Unlimited

additional notes

- After initial purchase, replacement contact lenses may be obtained online at substantial savings and mailed directly to the member.
- Receive 20% discount on items purchased at participating providers not included under the program. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses.
- Retail prices may vary by location.

plan limitations/exclusions:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear
- Services provided as a result of any Worker's Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)

SS325-1911

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

Locate an EyeMed provider convenient to you at:

www.deltadentalwi.com/vision

866-246-9041

When scheduling an appointment, inform the provider that you have a vision discount plan through the **EyeMed Access** panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the **EyeMed Access Plan**.

Providers: This is NOT insurance - it is a vision discount plan.

Locate an EyeMed provider convenient to you at:

www.deltadentalwi.com/vision

866-246-9041

When scheduling an appointment, inform the provider that you have a vision discount plan through the **EyeMed Access** panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the **EyeMed Access Plan**.

Providers: This is NOT insurance - it is a vision discount plan.

Delta Dental is a Registered Mark of Delta Dental Plans Association.

Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more. That's why Kiel Area School District provides vision care administered by Delta Vision. ***Please keep in mind that you can use the Delta Dental vision discount card, or use this vision insurance, but not both.***

Delta Vision	In-Network	Out-of-Network
Frequency		
Vision Exam		Once per 12 months
Frame		Once per 24 months
Lenses		Once per 12 months
Contact Lenses	Once per 12 months	
Copays		
Exam		$10
Materials		$10
Annual Vision Exam	Covered in Full after Copay	Up to $35
Contact Lens *(fit and follow-up)*	Up to $40	No Coverage
Standard Plastic Lenses		
Single	Covered in Full after Copay	Up to $25
Bifocal	Covered in Full after Copay	Up to $40
Trifocal	Covered in Full after Copay	Up to $55
Allowance Summary		**Up To**
Frames	$150 Allowance, then 15% off	$75
Conventional Contacts	$150 Allowance, then 15% off	$120
Disposable Contacts	$150 Allowance	$120

Refer to the Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) for detailed vision plan coverage information.

Monthly Premiums	Employee Cost
Employee	$6.45
Family	$16.06

GROUP LONG TERM DISABILITY (LTD)

Kiel Area School District's Long Term Disability plan is administered by The Standard.

This benefit pays a *monthly* percentage of your salary if you become disabled and are unable to work for an extended period of time. You are eligible for this benefit if you are a regular employee actively working at least 30 hours per week.

Premium	Employer Paid
Monthly Benefit	90% to $10,125
Elimination Period	90 Days
Maximum Benefit Duration	To Age 65

NOTE: *Please review the plan summaries for more details, including any limitations that might apply.*

VOLUNTARY SHORT TERM DISABILITY (STD) new

Kiel Area School District's Short Term Disability plan is administered by The Standard and employee paid. This benefit pays a non-taxable ***weekly*** percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to **your own** sickness or injury. Disability of your family members will not qualify as an approved Short Term Disability Claim. **Not all FMLA approved leaves are eligible Short Term Disability.**

Premium	Employee Paid
Weekly Benefit (non-taxable)	60% to $1,000
Sickness Benefit Begins On	8th Day
Accident Benefit Begins On	8th Day
Maximum Benefit Duration	83 Days

**Late enrollees (those that do not enroll during this one-time Open Enrollment, or within 30 days of hire) will not be required to submit evidence of insurability. They will instead be subject to a 60-day benefit waiting period for sickness or pregnancy during their first 12 months in the plan.*

Pregnancy payout periods (maximum benefit period) are from the general medical community. A standard vaginal pregnancy warrants a 6 week recovery and 8 weeks for c-section. Benefits become payable once you meet the 7 day benefit waiting period, there would 5 weeks of benefits for standard pregnancies and 7 weeks for c-section.

Standard: 6 week recovery less 7 day waiting period = 5 payable weeks.
C-section: 8 week recovery less 7 day waiting period = 7 payable weeks.

If you elect STD coverage outside of this one time open enrollment/as a late entrant and file a pregnancy claim within the first 12 months, no benefits would be payable for a standard or c-section pregnancy. This is because the 60 day wait is longer than the 6 or 8 week recovery period. If a pregnancy claim has complications and warrants a longer recovery period than 60 days, STD benefits would begin on the 61st day.

Frequently Asked Questions About The Standard's Maternity Guidelines When Filing a Short Term Disability (STD) Claim

The following questions and answers will help guide you through the claim filing process with Standard Insurance Company (The Standard) should you become disabled as result of pregnancy or childbirth.

When Should I File a Short Term Disability (STD) Claim as Result of a Pregnancy or Childbirth?

Please file your claim for STD benefits as soon as you cease working due to your pregnancy or childbirth. You may also report a claim up to four weeks in advance of a planned disability (expected delivery date or childbirth).

When Am I Considered Disabled as Result of My Pregnancy?

You are considered disabled when, as result of your pregnancy, you are unable to perform with reasonable continuity the material duties of your own job. If your pregnancy is normal and uncomplicated, the disability period begins on the cease work date but not earlier than between two and twenty weeks (depending on your type of occupation) before the expected date of delivery. Please refer to the Group Policy for the exact Definition of Disability.

Do Benefits Begin on the First Day of Disability?

Benefits become payable once you have served the benefit waiting period. The benefit waiting period means the period you must be continuously disabled before STD benefits become payable. No STD benefits are payable for the benefit waiting period. Please refer to the Group Policy for the length of your benefit waiting period.

If My Claim for Benefits is Approved, How Long Will it Take to Receive My First Payment?

If benefits become payable, The Standard may issue a lump sum payment for the expected disability period. When a lump sum payment cannot be issued, STD payments are paid by check in arrears on a weekly basis and mailed on Wednesday.

How Long Am I Considered Disabled Following Childbirth?

For all occupations you are considered disabled for six weeks after an uncomplicated vaginal delivery or eight weeks after a caesarian delivery. Disability periods assume there are no complications following childbirth. The disability period may be extended if complications arise.

What Happens if My Delivery Occurs Within the Benefit Waiting Period? Do I Still Receive Six Weeks of Benefits?

STD benefits are only payable for the period of disability following the benefit waiting period. Following an uncomplicated vaginal delivery, you are considered disabled for six weeks. This means in some instances when childbirth occurs during the benefit waiting period, benefits will be paid for less than six weeks.

Should I Contact The Standard if I Filed My Claim Before Childbirth?

If your claim was filed prior to your delivery date, please call us to report actual delivery date and type of delivery.

What Should I Do if I Have Complications Following My Childbirth?

If complications arise following childbirth preventing you from recovering during the normal recovery period, your doctor will need to provide us with written documentation of your specific limitations and restrictions. This documentation may include the completion of an attending physician's statement or pregnancy questionnaire, and/or copies of your medical records. You will receive an attending physician statement or pregnancy questionnaire, for you to take to your doctor, with the letter notifying you of our claim decision. If you did not receive a form, please contact us at 800.368.2859 to request one or send copies of your medical records. Once this information has been received, your claim will be reviewed for an extension of STD benefits.

Are Benefits Paid for Periods of Child-Parent Bonding, Breast Feeding, or Child Illness?

Disability benefits are paid only while you are unable to work at your own job due to childbirth. The actual amount and length benefits are paid is based on your Group Policy. No benefits are paid for periods of child-parent bonding, breast feeding, or child illness.

How Long Does It Normally Take for a Claim Decision?

Generally, once we receive a completed claim application, it will take approximately one week to make a claim decision. If a decision is not made within a week, you will be notified with details.

Who Should I Call with Questions About My Claim?

For general questions about your claim, please call The Standard's Disability Benefits toll-free number, 800.368.2859. A knowledgeable Customer Service Representative will be happy to assist you

GROUP LIFE INSURANCE

GROUP TERM LIFE

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a payment if you pass away while employed by Kiel Area School District. As an eligible employee, you are covered for Group Term Life insurance at no cost to you. You are eligible for this benefit if you are an active employee of Kiel Area School District and regularly working at least 30 hours each week.

Premium	Employer Paid
Amount of Life Insurance Benefit	1x Annual Earnings to a Maximum of $200,000 Minimum Benefit of $50,000

VOLUNTARY LIFE AND AD&D INSURANCE

In addition to the Group Term Life insurance, you have the option to purchase Supplemental Life and/or AD&D Insurance coverage for you and your eligible family members.

Employee Coverage ($10,000 increments)	Guarantee Issue: $250,000 | Maximum: $300,000
Spouse Coverage ($5,000 increments)	Guarantee Issue: $50,000 | Maximum: $150,000
Child Coverage ($5,000 increments)	Guarantee Issue: $10,000 | Maximum: $10,000

EMPLOYEE & SPOUSE LIFE RATES

Age	Employee Per $1,000	Spouse Per $1,000
Under 25	$0.05	$0.05
25-29	$0.06	$0.06
30-34	$0.08	$0.08
35-39	$0.09	$0.09
40-44	$0.10	$0.10
45-49	$0.15	$0.15
50-54	$0.23	$0.23
55-59	$0.43	$0.43
60-64	$0.66	$0.66
65-69	$1.27	$1.27
70 and over	$2.06	$2.06

CHILD LIFE RATES (per $1,000)

Voluntary Term Life	$0.20

EMPLOYEE, SPOUSE, AND CHILD AD&D RATES (per $1,000)

Employee	$0.02
Spouse	$0.02
Child	$0.03

Specific details of the plans are covered in the Plan Certificates.

Employee Assistance Program (EAP)

A FREE BENEFIT FOR YOU AND YOUR FAMILY

The Employee Assistance Program (EAP) through Aurora is offered to you and any family member living in your household at no cost to you. If assistance is needed beyond the scope of Aurora EAP, you will be referred to appropriate resources.

The Aurora EAP makes every effort to protect your privacy and ensure that your EAP service is completely confidential. They strictly adhere to the federal and state laws that regulate mental health and medical treatment records.

GIVE AURORA EAP A CALL

Call 800-236-3231 and identify yourself as an employee of Kiel Area School District.

How Aurora EAP works

Help begins as soon as you make the first call. They will listen to your concerns and ask questions about your current situation. Based on your needs, they will either:

- Connect you directly with an EAP counselor
- Schedule a consultation at a convenient time for you, or
- Link you with specialized work-life services

As you speak with an Aurora EAP counselor during an in-person or phone consultation, you may be offered a variety of suggestions, such as a referral to a support group, community resources, or counseling. Sometimes simply talking with the EAP counselor and hearing some suggestions is all that is needed.

When to use the Aurora EAP

Consider calling the EAP when a problem occupies too much of your time, interferes with normal activities, or persists for more than 2-3 weeks.

Typical concerns may include: alcohol/drug abuse, anxiety or depression, balancing work and family, caring for aging parents, child/family concerns, divorce, financial pressures, finding quality and cost-effective child care, legal issues, relationship issues, or workplace stresses.

Work-life services

All of the following work-life balance services are available as part of your EAP benefit:

- Childcare and elder care consultation, information and referral.
- Educational resource assistance for K-12 and higher education. They will match families with private and public schools from kindergarten through college and assist with choosing the most appropriate options. They can also help families understand financial aid options and assist with scholarship opportunities.
- Adoption information.
- Legal consultation and mediation services. We provide a free 30-minute consultation with an experienced attorney in your area.
- Financial consultation. Our financial experts provide up to 30 minutes of free phone consultation service and can help you address your financial concerns, such as bankruptcy or debt management.
- Unlimited access to web based work-life services, including search forms and calculators.

REQUIRED FEDERAL NOTICES

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment 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 towards 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).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: July 1, 2025

Who will follow this notice:

This notice describes the health information practices of Kiel Area School District (the "Plan") and that of any third party that receives medical information from or for us to assist us in providing your medical, dental, vision & FSA benefits benefits.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the "Rule"). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to Kiel Area School District ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medial information if you are a member of the armed forces and this is required by military command authorities.

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266 All requests for amendment of your medical information must include a reason to support the requested amendment.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

You have the right to request an "accounting of disclosures," where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of April 14, 2003

To request an accounting of disclosures, address your request to the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan's use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266.

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at the Plan's website www.kiel.k12.wi.us.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

To obtain a paper copy of this notice, contact the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266.

You have the right to be notified following a breach of unsecured protected health information.

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266.

You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your Plan Administrator 920.894.2266

MEDICARE PART D: CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kiel Area School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Kiel Area School District has determined that the prescription drug coverage offered by UMR is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage **and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Kiel Area School District coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Kiel Area School District coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Kiel Area School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information (Or call Becky O'Leary at 920.894.2266 **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kiel Area School District changes. You also may request a copy of this notice at any time.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

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

For more information about Medicare prescription drug coverage:

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

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

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

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURNACE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the "minimum value"1 standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION ABOUT THE MARKETPLACE?

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

1
An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs..

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name Kiel Area School District
Employer Identification Number (EIN): 39-6002808
Employer Address: 416 Paine Street Kiel, WI 53042
Employer Phone Number: 920.894.2266
Who can we contact about employee health coverage at this job? Phone Number (if different from above): Becky O'Leary at boleary@kiel.k12.wi.us or 920.894.2266

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.

- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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

HIBI Customer Service: 1-855-692-6442	

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/	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.h

Phone: 1-800-657-3672	tm 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**
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)

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 920.894.2266 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.