

# Roanoke County Public Schools Employee Benefit Guide 2026 - 2027

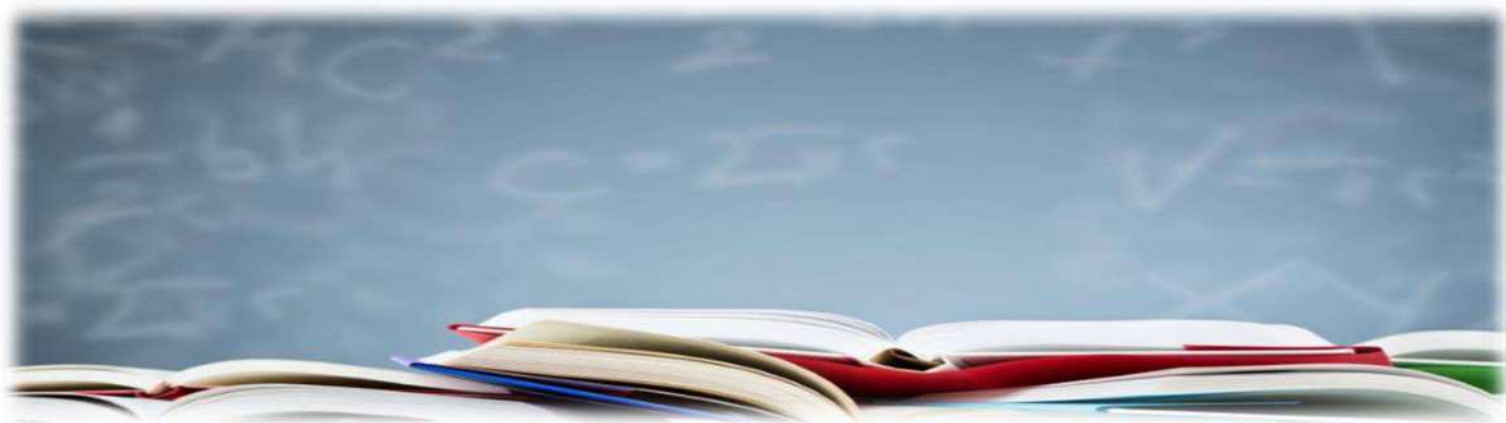


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Information contained in this insurance and benefits booklet is not a guarantee of benefits. Our summary plan descriptions and SPD Wrap Document are the guiding legal documents for our plans. If there are any discrepancies between this booklet and the legal summary from the insurance carrier, the carrier's documentation will prevail.

# Welcome – A Message from HR



Roanoke County Public Schools mission is preparing every student, in every school, and in every classroom to be Opportunity Ready. We accomplish this together through our talented and dedicated workforce. We appreciate and value each of your contributions and are pleased to offer a comprehensive benefits program for you and your families. This guide provides you with details about those benefits so you can make informed decisions.

The HR Department Staff and contact information as well as additional information on our benefits resources, provider information, and more can be found on [www.rcpsbenefits.com](http://www.rcpsbenefits.com). All of us in HR are here to help. Please do not hesitate to reach out to us with questions.

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Additional Links (To view choose CTRL + Click):

- [Employee Offers](#)
- [RCPS HR Directory](#)
- [www.rcpsbenefits.com](http://www.rcpsbenefits.com)

We're excited to announce a new partnership designed to make your benefits experience smoother, clearer, and more convenient than ever! Innovative Insurance Group (IIG) will be our go to partner for benefit guidance, enrollment support, and ongoing assistance. During Open Enrollment, the experts at IIG will be available to help you understand your benefit options, compare plans, and make confident choices. Throughout the year, IIG will continue to support you with customer service and claims assistance.

- ENROLLMENT CALL CENTER 888-605-3003
- CUSTOMER SERVICE 888-605-3003
- [customerservice@thinkinnovative.net](mailto:customerservice@thinkinnovative.net)

# Open Enrollment

Open Enrollment is April 20th - May 11th. All benefits elections and waivers must be entered in GHR no later than May 11th. Your changes will be effective July 1, 2026 and will be reflected on your July 15, 2026 paycheck. During Open Enrollment, you may make changes without a Qualifying Life Event.

**Action Required:** This year's Open Enrollment is **Mandatory Active Enrollment** for all eligible employees. You **must** take action to select or waive your benefits. If you do not enroll, **your current coverage will end on June 30, 2026.**

## PLAN HIGHLIGHTS FOR 2026:

- No Major Plan Design Changes - deductibles, coinsurance levels, and overall coverage structures remain the same.
  - HDHP Reminder - If you're enrolled in the High-Deductible Health Plan (HDHP), there is no fourth-quarter deductible carryover. Your deductible and out-of-pocket maximums reset on January 1, 2027.
- Anthem's Rx Cost Relief Program - We're implementing Anthem's Rx Cost Relief Program to help members save on specialty medications and biosimilars. These include treatments for rheumatoid arthritis, multiple sclerosis, and certain cancers — among the most costly prescriptions. This program helps control rising drug costs and keeps premiums manageable for everyone.
- Employee & Employer Contributions
  - Employee premium contributions will increase by 10%.
  - Employer costs are increasing by more than 22.5%, underscoring our continuing investment in your benefits.
  - HRA and HSA employer contributions remain unchanged across all plan options. (For Wellness Program Participants)
  - New for 2026! An Employee + Children tier is now available under both health and vision plans — offering a cost-effective option for single parents or those with dependent children only.
  - Evaluate all your options. The HDHP with a HSA may be a smart savings strategy. Review coverage options offered by your spouse's employer, if applicable. Use HSA or FSA to save tax dollars.
- Transition to Empower for FSA, HSA, and HRA
  - Beginning July 1, Empower will become our new third-party administrator for Flexible Spending Account (FSA), Health Savings Account (HSA), and Health Reimbursement Arrangement (HRA).
  - More details about your account transfer from Flexible Benefit Administrators to Empower will be provided.
- FSA Reminders
  - The Healthcare FSA carryover increased from \$660 to \$680 for 2026. This means that funds up to \$680 will carryover at year end (June 30) into the next plan year beginning July 1. Additionally, the annual contribution amount increased from \$3,300 to \$3,400.
  - September 15th is the deadline to submit Dependent Care FSA claims that were incurred through the end of the plan year (June 30).
- Dental Plan Updates
  - After several years without rate changes, Delta Dental premiums will increase this year.
  - The plan year will now align with our fiscal plan year, changing to July 1, 2026 – June 30, 2027.
  - Deductibles and out-of-pocket maximums reset on July 1.
  - New dental ID cards will be issued to enrolled employees.

# Eligibility

## Eligible Employees:

You may enroll in the Roanoke County Public Schools' Medical, Dental, and Vision programs if you are a full-time or part-time contracted employee.

## Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship.

### Please Note:

Employees must show proof of their dependents (i.e., marriage certificates, birth certificates, adoption paperwork, court orders, hospital birth records, custody agreements, qualified medical child support orders, or divorce decrees)

## When Coverage Begins:

Insurance for new hire employees on a 230, 240 and 260 contract starting work on the first working day of July will have coverage effective July 1. Insurance for beginning of the school year - new hire employees on a 220 day contract will be effective August 1. Insurance for beginning of the year new hire employees on a 210 and below contract will go into effect September 1. Insurance benefits for all new mid-year hires will be effective the first of the month following the date of hire.

All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualifying life event. Benefit enrollments or changes made during open enrollment become effective on July 1<sup>st</sup>. The effective date of your benefit enrollments or changes at the time of a life event are dependent upon the date of the event. The plan year begins on July 1st and ends on June 30th.

## Changes in Benefit Elections

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year, July 1st. During Open Enrollment, you can:

- Enroll, cancel or change the coverage tier on health, dental, and vision insurance plans.
- Add, or drop dependents from coverage. Note: You will be required to show proof of dependent eligibility (i.e., marriage certificates, birth certificates, adoption paperwork, court orders, hospital birth records, custody agreements, qualified medical child support orders, or divorce decrees) if you are adding a new dependent to your coverage.
- Enroll, or re-enroll in dependent or health care flexible spending accounts. *To continue your FSA benefits, you must re-enroll each plan year.*
- Change your insurance deduction from pre-tax status to after-tax status.

## Family Status Change:

A life event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such an event occurs, you must make the change to your benefits for most life events within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please use GHR Employee Space to make these changes. Instructions for GHR can be found on [rcpsbenefits.com](http://rcpsbenefits.com).

# Health Premiums

For the 2026-2027 plan year, Roanoke County Public Schools will offer three medical and prescription drug plan options through Anthem. The charts shown on the next few pages reflect a brief outline of what is offered, and the premium amounts based on the coverage tier. Please refer to the summary plan description [www.rcpsbenefits.com/](http://www.rcpsbenefits.com/) for complete plan details. Employees MUST provide documentation to show that their dependents are eligible for the School's health plans.

| KeyCare 1000 PPO       |                  |              |               |                |
|------------------------|------------------|--------------|---------------|----------------|
| 12-Month Full-Time     | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$203.50         | \$929.62     | \$1,133.12    | \$101.75       |
| Employee + 1 Child     | \$549.46         | \$1,150.22   | \$1,699.68    | \$274.73       |
| Employee + Children    | \$713.86         | \$1,325.76   | \$2,039.62    | \$356.93       |
| Employee + Spouse      | \$895.40         | \$1,370.84   | \$2,266.24    | \$447.70       |
| Family                 | \$1,159.96       | \$1,672.84   | \$2,832.80    | \$579.98       |
| Family - School Couple | \$590.16         | \$2,242.64   | \$2,832.80    | \$295.08       |
| 11-Month Full-Time     | Employee         | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$222.00         | \$1,014.14   | \$1,236.14    | \$111.00       |
| Employee + 1 Child     | \$599.42         | \$1,254.78   | \$1,854.20    | \$299.71       |
| Employee + Children    | \$778.76         | \$1,446.28   | \$2,225.04    | \$389.38       |
| Employee + Spouse      | \$976.80         | \$1,495.46   | \$2,472.26    | \$488.40       |
| Family                 | \$1,265.40       | \$1,824.92   | \$3,090.32    | \$632.70       |
| Family - School Couple | \$643.80         | \$2,446.52   | \$3,090.32    | \$321.90       |
| 10-Month Full-Time     | Employee         | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$244.20         | \$1,115.54   | \$1,359.74    | \$122.10       |
| Employee + 1 Child     | \$659.36         | \$1,380.26   | \$2,039.62    | \$329.68       |
| Employee + Children    | \$856.62         | \$1,590.92   | \$2,447.54    | \$428.31       |
| Employee + Spouse      | \$1074.48        | \$1,645.00   | \$2,719.48    | \$537.24       |
| Family                 | \$1,391.96       | \$2,007.40   | \$3,399.36    | \$695.98       |
| Family - School Couple | \$708.20         | \$2,691.16   | \$3,399.36    | \$354.10       |

| HealthKeepers 2000 HMO |                  |              |               |                |
|------------------------|------------------|--------------|---------------|----------------|
| 12-Month Full-Time     | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$102.46         | \$918.14     | \$1,020.60    | \$51.23        |
| Employee + 1 Child     | \$397.90         | \$1,133.00   | \$1,530.90    | \$198.95       |
| Employee + Children    | \$551.12         | \$1,285.96   | \$1,837.08    | \$275.56       |
| Employee + Spouse      | \$693.30         | \$1,347.90   | \$2,041.20    | \$346.65       |
| Family                 | \$907.34         | \$1,644.16   | \$2,551.50    | \$453.67       |
| Family - School Couple | \$337.54         | \$2,213.96   | \$2,551.50    | \$168.77       |
| 11-Month Full-Time     | Employee         | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$111.78         | \$1,001.60   | \$1,113.38    | \$55.89        |
| Employee + 1 Child     | \$434.08         | \$1,236.00   | \$1,670.08    | \$217.04       |
| Employee + Children    | \$601.22         | \$1,402.86   | \$2,004.08    | \$300.61       |
| Employee + Spouse      | \$756.32         | \$1,470.44   | \$2,226.76    | \$378.16       |
| Family                 | \$989.84         | \$1,793.62   | \$2,783.46    | \$494.92       |
| Family - School Couple | \$368.24         | \$2,415.22   | \$2,783.46    | \$184.12       |
| 10-Month Full-Time     | Employee         | Monthly RCPS | Total Premium | Per Pay Period |
| Employee Only          | \$122.96         | \$1,101.76   | \$1,224.72    | \$61.48        |
| Employee + 1 Child     | \$477.48         | \$1,359.60   | \$1,837.08    | \$238.74       |
| Employee + Children    | \$661.34         | \$1,543.16   | \$2,204.50    | \$330.67       |
| Employee + Spouse      | \$831.96         | \$1,617.48   | \$2,449.44    | \$415.98       |
| Family                 | \$1,088.80       | \$1,973.00   | \$3,061.80    | \$544.40       |
| Family - School Couple | \$405.04         | \$2,656.76   | \$3,061.80    | \$202.52       |

\*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

# Health Premiums Continued

| <b>HealthKeepers 3400 HMO</b> |                         |                     |                      |                       |
|-------------------------------|-------------------------|---------------------|----------------------|-----------------------|
| <b>12-Month Full-Time</b>     | <b>Monthly Employee</b> | <b>Monthly RCPS</b> | <b>Total Premium</b> | <b>Per Pay Period</b> |
| Employee Only                 | \$0.00                  | \$906.50            | \$906.50             | \$0.00                |
| Employee + 1 Child            | \$244.20                | \$1,115.56          | \$1,359.76           | \$122.10              |
| Employee + Children           | \$358.98                | \$1,272.72          | \$1,631.70           | \$179.49              |
| Employee + Spouse             | \$488.40                | \$1,324.60          | \$1,813.00           | \$244.20              |
| Family                        | \$651.20                | \$1,615.06          | \$2,266.26           | \$325.60              |
| Family - School Couple        | \$81.40                 | \$2,184.86          | \$2,266.26           | \$40.70               |
| <b>11-Month Full-Time</b>     | <b>Employee</b>         | <b>Monthly RCPS</b> | <b>Total Premium</b> | <b>Per Pay Period</b> |
| Employee Only                 | \$0.00                  | \$988.90            | \$988.90             | \$0.00                |
| Employee + 1 Child            | \$266.40                | \$1,216.98          | \$1,483.38           | \$133.20              |
| Employee + Children           | \$391.62                | \$1,388.42          | \$1,780.04           | \$195.81              |
| Employee + Spouse             | \$532.80                | \$1,445.02          | \$1,977.82           | \$266.40              |
| Family                        | \$710.40                | \$1,761.88          | \$2,472.28           | \$355.20              |
| Family - School Couple        | \$88.80                 | \$2,383.48          | \$2,472.28           | \$44.40               |
| <b>10-Month Full-Time</b>     | <b>Employee</b>         | <b>Monthly RCPS</b> | <b>Total Premium</b> | <b>Per Pay Period</b> |
| Employee Only                 | \$0.00                  | \$1,087.80          | \$1,087.80           | \$0.00                |
| Employee + 1 Child            | \$293.04                | \$1,338.68          | \$1,631.72           | \$146.52              |
| Employee + Children           | \$430.78                | \$1,527.26          | \$1,958.04           | \$215.39              |
| Employee + Spouse             | \$586.08                | \$1,589.52          | \$2,175.60           | \$293.04              |
| Family                        | \$781.44                | \$1,938.08          | \$2,719.52           | \$390.72              |
| Family - School Couple        | \$97.68                 | \$2,621.84          | \$2,719.52           | \$48.84               |

\*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

# Glossary of Health Care Terms

Below is a list of common terms associated with a health insurance plan. Understanding what these terms mean can help you better understand your benefits and what you might owe at the time of service.



## **Copay**

A flat fee you pay for covered services, such as doctor visits.



## **Deductible**

The set amount you pay before your plan begins to share the cost for covered health services.



## **Your percentage of the costs (coinsurance)**

After you pay your deductible, this is your percentage of costs each time you get care.



## **Out-of-pocket limit**

The maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, your plan covers the rest.

# Traditional Medical Plan Summaries

|  | Anthem<br>KeyCare 1000 PPO |                         |
|--|----------------------------|-------------------------|
|  | In-Network Benefits        | Out-of-Network Benefits |
| <b>Annual Deductible</b>                 |                            |                         |
| Individual (embedded)                    | \$1,000                    | \$1,500                 |
| Family (embedded)                        | \$2,000                    | \$3,000                 |
| Coinsurance                              | 80%                        | 60%                     |
| <b>Maximum Out-of-Pocket*</b>            |                            |                         |
| Individual                               | \$3,500                    | \$5,250                 |
| Family                                   | \$7,000                    | \$10,500                |
| <b>Physician Office Visit</b>            |                            |                         |
| Primary Care                             | 20% after deductible       | 40% after deductible    |
| Specialty Care                           | 20% after deductible       | 40% after deductible    |
| <b>Preventive Care</b>                   |                            |                         |
| Adult Periodic Exams                     | 100%                       | 40% after deductible    |
| Well-Child Care                          | 100%                       | 40% after deductible    |
| <b>Diagnostic Services</b>               |                            |                         |
| X-ray and Lab Tests                      | 20% after deductible       | 40% after deductible    |
| Complex Radiology                        | 20% after deductible       | 40% after deductible    |
| Urgent Care Facility                     | 20% after deductible       | 40% after deductible    |
| Emergency Room Facility Charges*         | 20% after deductible       | 40% after deductible    |
| Inpatient Facility Charges               | 20% after deductible       | 40% after deductible    |
| Outpatient Facility and Surgical Charges | 20% after deductible       | 40% after deductible    |
| <b>Mental Health</b>                     |                            |                         |
| Inpatient                                | 20% after deductible       | 40% after deductible    |
| Outpatient                               | 20% after deductible       | 40% after deductible    |
| <b>Substance Abuse</b>                   |                            |                         |
| Inpatient                                | 20% after deductible       | 40% after deductible    |
| Outpatient                               | 20% after deductible       | 40% after deductible    |
| <b>Other Services</b>                    |                            |                         |
| Chiropractic                             | 20% after deductible       | 40% after deductible    |

- This is a high-level overview of benefits only. For complete Medical Benefit Summary, Summary of Benefit and coverage, and detailed benefits overview, visit [www.rcpsbenefits.com/](http://www.rcpsbenefits.com/)

# Traditional Medical Plan Summaries

|  | Anthem Blue Cross Blue Shield<br>HealthKeepers 2000 HMO |                         |
|--|---|-------------------------|
|  | In-Network Benefits                                     | Out-of-Network Benefits |
| <b>Annual Deductible</b>                 |   |                         |
| Individual (embedded)                    | \$2,000   | \$3,000                 |
| Family (embedded)                        | \$4,000   | \$6,000                 |
| Coinsurance                              | 80%   | 60%                     |
| <b>Maximum Out-of-Pocket*</b>            |   |                         |
| Individual                               | \$5,000   | \$7,500                 |
| Family                                   | \$10,000  | \$14,000                |
| <b>Physician Office Visit</b>            |   |                         |
| Primary Care                             | 20% after deductible                                    | 40% after deductible    |
| Specialty Care                           | 20% after deductible                                    | 40% after deductible    |
| <b>Preventive Care</b>                   |   |                         |
| Adult Periodic Exams                     | 100%  | 40% after deductible    |
| Well-Child Care                          | 100%  | 40% after deductible    |
| <b>Diagnostic Services</b>               |   |                         |
| X-ray and Lab Tests                      | 20% after deductible                                    | 40% after deductible    |
| Complex Radiology                        | 20% after deductible                                    | 40% after deductible    |
| Urgent Care Facility                     | 20% after deductible                                    | 40% after deductible    |
| Emergency Room Facility Charges*         | 20% after deductible                                    | 40% after deductible    |
| Inpatient Facility Charges               | 20% after deductible                                    | 40% after deductible    |
| Outpatient Facility and Surgical Charges | 20% after deductible                                    | 40% after deductible    |
| <b>Mental Health</b>                     |   |                         |
| Inpatient                                | 20% after deductible                                    | 40% after deductible    |
| Outpatient                               | 20% after deductible                                    | 40% after deductible    |
| <b>Substance Abuse</b>                   |   |                         |
| Inpatient                                | 20% after deductible                                    | 40% after deductible    |
| Outpatient                               | 20% after deductible                                    | 40% after deductible    |
| <b>Other Services</b>                    |   |                         |
| Chiropractic                             | 20% after deductible                                    | 40% after deductible    |

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# High Deductible Health Plan Medical Plan Summary

|  | Anthem Blue Cross Blue Shield<br>HealthKeepers 3400 HMO |                         |
|--|---|-------------------------|
|  | In-Network Benefits                                     | Out-of-Network Benefits |
| <b>Annual Deductible</b>                 |   |                         |
| Individual (embedded)                    | \$3,400   | \$4,000                 |
| Family (embedded)                        | \$6,800   | \$8,000                 |
| Coinsurance                              | 80%   | 60%                     |
| <b>Maximum Out-of-Pocket*</b>            |   |                         |
| Individual                               | \$6,000   | \$7,500                 |
| Family                                   | \$12,000  | \$14,000                |
| <b>Physician Office Visit</b>            |   |                         |
| Primary Care                             | 20% after deductible                                    | 40% after deductible    |
| Specialty Care                           | 20% after deductible                                    | 40% after deductible    |
| <b>Preventive Care</b>                   |   |                         |
| Adult Periodic Exams                     | 100%  | 40% after deductible    |
| Well-Child Care                          | 100%  | 40% after deductible    |
| <b>Diagnostic Services</b>               |   |                         |
| X-ray and Lab Tests                      | 20% after deductible                                    | 40% after deductible    |
| Complex Radiology                        | 20% after deductible                                    | 40% after deductible    |
| Urgent Care Facility                     | 20% after deductible                                    | 40% after deductible    |
| Emergency Room Facility Charges*         | 20% after deductible                                    | 40% after deductible    |
| Inpatient Facility Charges               | 20% after deductible                                    | 40% after deductible    |
| Outpatient Facility and Surgical Charges | 20% after deductible                                    | 40% after deductible    |
| <b>Mental Health</b>                     |   |                         |
| Inpatient                                | 20% after deductible                                    | 40% after deductible    |
| Outpatient                               | 20% after deductible                                    | 40% after deductible    |
| <b>Substance Abuse</b>                   |   |                         |
| Inpatient                                | 20% after deductible                                    | 40% after deductible    |
| Outpatient                               | 20% after deductible                                    | 40% after deductible    |
| <b>Other Services</b>                    |   |                         |
| Chiropractic                             | 20% after deductible                                    | 40% after deductible    |

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# Frequently Asked Questions about the Traditional Medical Plans

## KeyCare 1000 PPO

**Q: Are there any changes to the KeyCare 1000 health plan structure or to the premiums?**

A: There are no changes to the benefit plan this year, but the premiums have increased.

**Q: Are there co-pays for doctor visits in the KeyCare 1000 plan?**

A: No, the KeyCare 1000 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HRA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses.

**Q: What is the deductible on the KeyCare 1000 plan?**

A: If you have an employee only plan, the deductible is \$1,000. If you have other family members covered on the plan, there is a \$2,000 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$2,000. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$1,000.

**Q: Is this a calendar year deductible?**

A: Yes, it is calendar year, January-December.

**Q: What does the deductible mean as far as what I pay?**

A: Once you have paid your \$1,000/\$2,000 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$1,050. You will have to pay the first \$1,000 in full, and then you would only pay 20% of the other \$50.)

**Q: Is there any type of deductible carry-over?**

A: Yes, any deductible amount that is satisfied in the 4th quarter of the calendar year (October-December) will carry over towards the deductible for the next year.

**Q: What is my out-of-pocket maximum each calendar year?**

A: If you have a single plan, it is \$3,500 January-December. If you have any additional family members on your plan, it is \$7,000 January-December. (There is also a separate drug out-of-pocket maximum each calendar year of \$2,500 per member, January-December.)

**Q: Does my deductible count towards my out-of-pocket yearly maximum of \$3,500/\$7,000?**

A: Yes, the \$1,000/\$2,000 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

**Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?**

A: No, there are no co-pays for those services with the KeyCare 1000 health plan. But there is a 20% coinsurance for covered services.

**Q: Is there vision coverage on the KeyCare 1000 plan?**

A: Yes, a discount vision program is included with the KeyCare 1000 plan through Blue View Vision at no additional cost to the member.

**Q: Am I eligible to participate in the KeyCare 1000 option if I am part-time?**

A: Yes, you will be able to participate in the KeyCare 1000 medical plan.

**Q: If I do not return for the new school year in August, when does my insurance end?**

A: Your insurance will end June 30, 2026.

## HealthKeepers 2000 HMO

**Q: Are there any changes to the HealthKeepers 2000 health plan structure or to the premiums?**

A: Yes, the 2000 plan is moving from the KeyCare PPO network to the HealthKeepers HMO network and the out-of-pocket maximums have increased to \$5,000/\$10,000.

**Q: Are there co-pays for doctor visits in the HealthKeepers 2000 plan?**

A: No, the HealthKeepers 2000 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HRA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses.

**Q: What is the deductible on the HealthKeepers 2000 plan?**

A: If you have an employee only plan, the deductible is \$2,000. If you have other family members covered on the plan, there is a \$4,000 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$4,000. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$2,000.

**Q: Is this a calendar year deductible?**

A: Yes, it is calendar year, January-December.

**Q: What does the deductible mean as far as what I pay?**

A: Once you have paid your \$2,000/\$4,000 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$2,050. You will have to pay the first \$2,000 in full, and then you would only pay 20% of the other \$50.)

**Q: Is there any type of deductible carry-over?**

A: Yes, any deductible amount that is satisfied in the 4th quarter of the calendar year (October-December) will carry over towards the deductible for the next year.

**Q: What is my out-of-pocket maximum each calendar year?**

A: If you have a single plan, it is \$5,000 January-December. If you have any additional family members on your plan, it is \$10,000 January-December. (There is no separate drug out-of-pocket maximum each calendar year like there is on the KeyCare \$1,000 plan.)

**Q: Does my deductible count towards my out-of-pocket yearly maximum of \$5,000/\$10,000?**

A: Yes, the \$2,000/\$4,000 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

**Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?**

A: No, there are no co-pays for those services with the HealthKeepers 2000 health plan. But there is a 20% coinsurance for covered services.

**Q: Is there vision coverage on the HealthKeepers 2000 plan?**

A: Yes, a discount vision program is included with the HealthKeepers 2000 plan through Blue View Vision at no additional cost to the member.

**Q: Am I eligible to participate in the HealthKeepers 2000 option if I am part-time?**

A: Yes, you will be able to participate in the HealthKeepers 2000 medical plan.

**Q: If I do not return for the new school year in August, when does my insurance end?**

A: Your insurance will end June 30, 2026.

# Frequently Asked Questions about the High Deductible Health Plan

## HealthKeepers 3400 HMO

### **Q: What is a High Deductible Health Plan (HDHP)?**

A: A High Deductible Health Plan is an IRS approved medical plan that can be paired with a Health Savings Account (**HSA**) that you can contribute pre-tax dollars to, to help offset your out-of-pocket health expenses. This plan is structured this way because there is no “first dollar coverage”, meaning that you must pay the full cost of the negotiated charge that is billed by your provider or pharmacy until you meet your medical deductible before Anthem shares the cost of covered services – even your prescription drugs.

### **Q: Are there co-pays for doctor visits in the HealthKeepers 3400 plan?**

A: No, the HealthKeepers \$3,400 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HSA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses. More information on HSA accounts is provided later in this benefit guide.

### **Q: What is the deductible on the HealthKeepers 3400 plan?**

A: If you have an employee only plan, the deductible is \$3,400. If you have other family members covered on the plan, there is a \$6,800 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$6,800. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$3,400.

### **Q: Is this a calendar year deductible?**

A: Yes, it is calendar year, January-December.

### **Q: What does the deductible mean as far as what I pay?**

A: Once you have paid your \$3,400/\$6,800 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$3,450. You will have to pay the first \$3,400 in full, and then you would only pay 20% of the remaining \$50.) With this plan, the same structure applies to pharmacy coverage. Once you meet the \$3,400, you will have a copay either \$10, \$40, or \$80 based on the drug tier until you meet your out-of-pocket maximum for the plan year.

### **Q: Is there any type of deductible carry-over?**

A: No.

### **Q: What is my out-of-pocket maximum each calendar year?**

A: If you have a single plan, it is \$6,000 January-December. If you have any additional family members on your plan, it is \$12,000 January-December. (There is no separate drug out-of-pocket maximum each calendar year like there is on the KeyCare \$1,000 plan.)

### **Q: Does my deductible count towards my out-of-pocket yearly maximum of \$6,000/\$12,000?**

A: Yes, the \$3,400/\$6,800 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

### **Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?**

A: No, there are no co-pays for those services with the HealthKeepers \$3,400 health plan. But there is a 20% coinsurance for all covered services after you’ve met your deductible.

### **Q: Is there vision coverage on the HealthKeepers 3400 plan?**

A: Yes, a discount vision program is included with the HealthKeepers \$3,400 plan through Blue View Vision at no additional cost to the member.

### **Q: Am I eligible to participate in the HealthKeepers 3400 option if I am part-time?**

A: Yes, you will be able to participate in the HealthKeepers \$3,400 medical plan.

### **Q: If I do not return for the new school year in August, when does my insurance end?**

A: Your insurance will end June 30, 2026.

# Prescription Benefits

| KeyCare 1000 PPO               | Anthem Rx (Carelton Rx)   |   |
|--------------------------------|---|---|
|                                | Retail Pharmacy 30-Day Supply   | Home Delivery 90-Day Supply   |
| Generic Drugs                  | \$10  | \$20  |
| Preferred Brand-Name Drugs     | \$25  | \$50  |
| Non-preferred Brand-Name Drugs | Greater of \$40 or 20% coinsurance up to \$100 maximum per prescription | Greater of \$80 or 20% coinsurance up to \$200 maximum per prescription |
| <b>Maximum Out-of-Pocket</b>   |   |   |
| Individual/ Family             | \$2,500/\$10,000  |   |

A 90-day supply of Maintenance Medications ONLY can be filled at participating retail pharmacies for 2-times the applicable retail copay.

| HealthKeepers 2000 HMO         | Anthem Rx (Carelton Rx)   |  |
|--------------------------------|---|--|
|                                | Retail Pharmacy 30-Day Supply   | Home Delivery 90-Day Supply  |
| Generic Drugs                  | \$10  | \$20   |
| Preferred Brand-Name Drugs     | \$40  | \$80   |
| Non-preferred Brand-Name Drugs | Greater of \$80 or 20% coinsurance up to \$200 maximum per prescription | Greater of \$160 or 20% coinsurance up to \$400 maximum per prescription |
| <b>Maximum Out-of-Pocket</b>   |   |  |
| Individual/Family              | Combined with Medical   |  |

| HealthKeepers 3400 HMO         | Anthem Rx (Carelton Rx)       |                               |
|--------------------------------|-------------------------------|-------------------------------|
|                                | Retail Pharmacy 30-Day Supply | Home Delivery 90-Day Supply   |
| Generic Drugs                  | \$10 <b>after deductible</b>  | \$20 <b>after deductible</b>  |
| Preferred Brand-Name Drugs     | \$40 <b>after deductible</b>  | \$80 <b>after deductible</b>  |
| Non-preferred Brand-Name Drugs | \$80 <b>after deductible</b>  | \$160 <b>after deductible</b> |
| <b>Maximum Out-of-Pocket</b>   |                               |                               |
| Individual/Family              | Combined with Medical         |                               |

## Prior Authorization: When is a coverage review necessary?

Some medications are not covered unless you first receive approval through a Prior Authorization review. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a Prior Authorization review. During this review, Anthem asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. To find out whether a medication requires a Prior Authorization review, your doctor can send a prior authorization form by fax to **1-844-521-6940** or call **1-833-293-0659** to speak to a Prior Authorization Specialist.

## Specialty medications: Get individualized service through US Specialty Care

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Carelon Rx, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week;
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge;
- Most supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent potential drug interactions;
- Refill reminders;
- Up to a 30-day supply of your specialty medication for just one copayment.

### KEEP THIS INFORMATION:

For more information about your benefit, log in on the Anthem site or call Member Services toll-free at (833) 388-1400.





## Skip the pharmacy with home delivery

# Have your long-term medications sent to your home with CarelonRx Pharmacy

Set up home delivery through CarelonRx Pharmacy for the prescriptions you take long-term for conditions like high blood pressure, diabetes, heart disease, or asthma. You'll receive your medications at your door and enjoy the convenience of not having to visit the pharmacy.

### With home delivery, you can count on:

**Convenience.** Medications are delivered directly to your home or any location you choose.

- Manage your prescriptions with the Sydney Health app or at [anthem.com](https://www.anthem.com).
- Expect first-time orders to take about five days to process. Refills take two days to process. Standard shipping time varies between 3 to 5 days.
- Track your order.
- Set up reminders and automatic refills, too.

**Savings.** Many medications cost less when you fill a 90-day supply instead of three 30-day supplies. Standard shipping is always free. With CarelonRx Pharmacy, you can also learn about lower-cost options.

**Safety.** A licensed pharmacist checks all orders before they ship. Discreet packaging is:

- Tamperproof
- Weatherproof
- Temperature controlled, if needed



**Peace of mind.** You're less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed when you switch to home delivery.\* You can also talk, text, or chat 24/7 with a trained pharmacist if you have questions or need help.

**Hassle-free service.** CarelonRx Pharmacy will contact your doctor to order a new, 90-day prescription if you need one. If a medication preapproval is needed, the home delivery team will reach out to you for consent before shipping your medication.

### We're here to help

Call the CarelonRx Pharmacy Contact Center at the number on your ID card or use the live chat feature on Sydney Health or [anthem.com](https://www.anthem.com).



### Start home delivery now

1. Log in to [anthem.com](https://www.anthem.com) and go to the **Prescriptions Home** page. You can also log in to your mobile app and select **Pharmacy** or scan the QR code with your phone's camera. Register your member account if you haven't already.
2. Go to **View Prescriptions** and follow the guided steps to switch to CarelonRx Pharmacy.

\* National Library of Medicine, National Center for Biotechnology. *A Retrospective Database Study Comparing Diabetes-Related Medication Adherence and Health Outcomes for Mail-Order Versus Community Pharmacy* (March 2019): ncbi.nlm.nih.gov.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. Services provided by CarelonRx, Inc. CarelonRx is an independent company providing pharmacy benefit management services on behalf of your health plan.

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# Here's relief from the high cost of specialty drugs

## Sign up to save with a \$0 copay

If you're taking a prescribed specialty medicine to manage your health condition, you know all too well that these treatments can come at a high cost.

**The good news is your prescription drug benefits include the money-saving Cost Relief program.** It helps keep costs as low as possible, with **\$0 copays**<sup>1</sup> on certain specialty drugs when you fill the prescription with the exclusive specialty pharmacy in your network. We take care of connecting you directly with drug manufacturers<sup>2</sup> who offer copay assistance.

## Start saving money on your specialty medicines with Cost Relief



<sup>1</sup> Pending any deductible requirements you may have as part of your plan. Your deductible is the amount you pay for covered health services before your insurance plan starts to pay. Members who have a high-deductible health plan with a health savings account are required to meet their deductible before they can receive a \$0 copay.

<sup>2</sup> Please note that even if a manufacturer does not offer copay assistance for your medicine(s) eligible for Cost Relief, your cost will be \$0 out of pocket if you are enrolled in Cost Relief and have met your deductible for the year.

<sup>3</sup> Manufacturers' assistance dollars do not apply towards accumulators regardless of enrollment status.

Services provided by CarelonRx, Inc.

CarelonRx, Inc., is an independent company providing pharmacy benefit management on behalf of your health plan.







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# Let's look at how Cost Relief works



## How Susan gets to a \$0 copay

Susan has a prescription for a specialty medicine that costs \$1,500 and is eligible for the Cost Relief program.

### Susan enrolls in the Cost Relief program

-  A Cost Relief representative reaches out to Susan to tell her about the program and begins Susan's enrollment process.
-  Once enrolled, the Cost Relief representative partners with Susan to connect her with drug manufacturers so she can sign up for their copay assistance.
-  Susan pays **\$0 for her prescription** thanks to the copay assistance applied to her current and future prescription fills.<sup>1</sup>
-  If Susan changes or starts a new specialty medicine eligible for the Cost Relief program, a representative will contact her about any available copay assistance and confirm her **\$0 out-of-pocket cost**.
-  Susan receives ongoing support to manage enrollment and renewals for copay programs.
-  If Susan has specific questions about her medicines, the Cost Relief representative connects her directly to specialty pharmacy staff.

### Susan does not enroll in the Cost Relief program

-  Susan is responsible for paying the coinsurance or copay of her prescription, which is based on her benefit plan.<sup>3</sup>
-  Susan can enroll in the program at any time to receive the **\$0 benefit** by speaking with a specialty pharmacy representative.

<sup>1</sup> Pending any deductible requirements you may have as part of your plan. Your deductible is the amount you pay for covered health services before your insurance plan starts to pay. Members who have a high-deductible health plan with a health savings account are required to meet their deductible before they can receive a \$0 copay.

<sup>2</sup> Please note that even if a manufacturer does not offer copay assistance for your medicine(s) eligible for Cost Relief, your cost will be \$0 out of pocket if you are enrolled in Cost Relief and have met your deductible for the year.

<sup>3</sup> Manufacturers' assistance dollars do not apply towards accumulators regardless of enrollment status.

Services provided by CarelonRx, Inc.

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# Prescription Benefits Frequently Asked Questions

## **Q. Where can I get my prescriptions filled?**

A. You can have your prescription filled at one of Anthem's 67,000 retail pharmacies. To find one near you, go to the Pharmacy Locator in the Anthem website.

## **Q. Do I need to take my ID card with me to the pharmacy every time?**

A. It is a good idea to carry your member ID card with you at all times. When you fill a prescription at a new pharmacy or start a new insurance plan, the pharmacist will need specific information on your member ID card. This information allows the pharmacy to fill your prescription properly, process your claim and tell you what your copay is at the time of purchase. Once you are in the pharmacy's system you should not have to show your ID card again.

## **Q. Why can't I get my prescription filled?**

A. There are many reasons why your prescription request might not process. Here are some common reasons.

- **Refill too soon** – your prescription can't be refilled before it's expected to run out. Contact your doctor and ask them to call Anthem to inquire about what is needed to request an early refill.
- **Quantity Limits** – based on your plan, your prescription might not be filled if the quantity requested is too high. Limits are placed for safety and to keep you from being overcharged.

## **Q. Why should I use Anthem Prescription Delivery Service (mail order)?**

A. The Anthem Prescription Delivery Service is a convenient and cost-effective way for you to order up to a 90-day supply of any medication that you take on a long-term basis, for delivery to your home or business. You will avoid having to visit a local pharmacy each month and save money on your prescriptions.

## **Q. How do I use the Prescription Delivery Service?**

A. Have your doctor write your prescription for the number of days your plan allows for mail service (for example 90 days).

- **Register Online:** Using the Member Portal, provide your mailing address, phone number, certain health information and payment information to get started with the service.
- **Mail:** Review and complete the Prescription Delivery Service form and return with a valid prescription.

## **Q. How long will it take to receive my prescription?**

A. You can expect to receive your prescription approximately 7 to 10 business days after Anthem receives your order. You can check the status of your order by signing into your online account or call Anthem Member Services.

## **Q. Will Anthem send me a refill reminder?**

A. Anthem will call or email you with a refill reminder, allowing you enough time to order before you finish your current supply. You then need to request a refill online through the Anthem member portal or call the automated phone system to place an order for the medication(s). You will be charged in accordance with the payment information you provided.

## **Q. What forms of payment does Anthem accept?**

A. Anthem accepts VISA, MasterCard, American Express, Discover, check, check by phone or money order as approved forms of payment. Payment cards for flexible spending accounts are also accepted. For your convenience, your credit card will be maintained on a secure site for future orders.

## **Q. How are prescriptions sent?**

A. Prescription Delivery Service orders are sent via first class U.S. Postal Service. If you choose to have your medicine rush ordered, additional costs will apply and vary by shipping method. All orders are shipped in unmarked, tamper-proof packaging to ensure security and complete confidentiality.

## **Q. What is the Retail90 Program?**

A. This is an alternative to the Prescription Delivery Service. Members can receive a 90-day maintenance medication at their local pharmacy at the same copay cost as the mail order program.

## **Q. How does Anthem protect my health information?**

A. Anthem complies with patient privacy regulations and requirements set by the Health Insurance Portability and Accountability Act (HIPAA). If you would like Anthem Rx to discuss and/or release your protected health information to another person or entity, you must authorize Anthem to do this by completing a Protected Health Information Authorization Form.

## **Q. Who can I call for help?**

A. If you have questions about your prescription benefit coverage, you can call Anthem Member Services, the phone number, 1-833-419-0530, listed on the back of your ID card.

\*Please note that how much your prescription costs out-of-pocket depends on the Anthem plan you're enrolled in, what tier the drug is in, and whether you must meet your entire medical deductible before the copays and/or coinsurance percentages apply (HDHP HealthKeepers 3400 HMO Plan).

# Use your preventive care benefits

Stay healthy and catch problems  
early for easier treatment



Our health plans offer all the preventive care services and immunizations below at no cost to you<sup>1</sup>. You won't have to pay anything when you use a doctor, pharmacy, or lab in your plan's network. If you go to doctors or facilities outside your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots are right for you, talk to your doctor.

## Preventive care vs. diagnostic care: Knowing the difference

**Preventive care** helps protect you from getting sick. If your doctor recommends services when you have no symptoms, that's preventive care. **Diagnostic care** is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms.

## Adult preventive care

### General preventive physical exams, screenings, and tests (all adults):

- Alcohol and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)<sup>2</sup>
- Diabetes screening (type 2)<sup>3</sup>
- Exercise interventions to prevent falls in adults over age 65

- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for adults aged 50 to 80 years who have a 20 pack year (packs per day X years of smoking) smoking history and currently smoke or have quit within the past 15 years<sup>2</sup>
- Obesity: related screening and counseling<sup>3</sup>
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

### **Women's preventive care:**

- Breast cancer screenings, including exams, mammograms
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling<sup>4,5,6,7</sup>
- Chlamydia and gonorrhea screening
- Contraceptive (birth control) counseling
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing for women with personal family history of breast, ovarian, tubal, or peritoneal cancer<sup>8</sup>
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening<sup>5</sup>
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression<sup>5</sup>
- Urinary incontinence screening
- Well-woman visits

### **Immunizations:**

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and are subject to change. They may not be right for every person. Ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the group policy provisions will rule. Please see your combined evidence of coverage (EOC) and disclosure form or certificate for exclusions and limitations.

## Child preventive care

### Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Hearing screening up to 21 years
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive medication: newborns
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer behavioral counseling for those ages 6 months to 24 years with fair skin
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 year<sup>9</sup>



### Immunizations:

- Chickenpox
- Flu
- Haemophilus influenzae type B (HIB)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Whooping cough

## Pharmacy item coverage

### For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network
- Have prescriptions, including for OTC items

### Women's preventive drugs and other pharmacy items (age appropriate):

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria<sup>2</sup>
- Contraceptives, including generic prescription drugs and OTC items like female and male condoms and spermicides<sup>7,8</sup>
- Folic acid for women who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

### Adult preventive drugs and other pharmacy items (age appropriate):

- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for members ages 45 to 75
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for members ages 18 and older

### Child preventive drugs and other pharmacy items (age appropriate):

- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children starting at 6 months for children whose water supply is deficient in fluoride

If you'd like more help understanding your preventive care benefits, call the Member Services number on your health plan ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the Preventive ACA Drug List flyer, available at [anthem.com/pharmacyinformation](http://anthem.com/pharmacyinformation).

<sup>1</sup>The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Member Services number on your ID card.

<sup>2</sup>You may be required to receive preapproval for these services.

<sup>3</sup>The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

<sup>4</sup>Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

<sup>5</sup>This benefit also applies to those younger than age 19.

<sup>6</sup>You may pay a share of the cost for other prescription contraceptives, based on your drug benefits. Your cost share may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

<sup>7</sup>Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.

<sup>8</sup>Check your medical policy for details.

<sup>9</sup>Some plans cover additional vision services. Please see your contract or certificate of coverage for details.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



# The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney<sup>SM</sup> Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

## Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

## My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

## Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

## Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

## Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

## My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

## ¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige el **idioma de la aplicación**. También puedes visitar [espanol.anthem.com](http://espanol.anthem.com).



## Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at [anthem.com/register](http://anthem.com/register) to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Caredon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](http://anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE<sup>SM</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>SM</sup> Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



# Get care from anywhere

Virtual visits on LiveHealth Online are an included benefit for Anthem medical plan members

## Get the care you need, virtually.

Looking for a quick and easy way to get care? With LiveHealth Online, you can access telehealth visits from anywhere. All you need is a smartphone, tablet, or computer!

## Care options available to you through LiveHealth Online:



**Annual Wellness.** Visits with primary care providers who can help with preventative screenings, chronic health concerns, follow-up care, and referrals for lab work and specialists as clinically appropriate.



**Therapy and Psychiatry.** See a therapist online from the comfort of your couch to get help for anxiety, depression, panic attacks, stress relief, and more. Psychiatrists are also available by appointment and can prescribe medication when talk therapy isn't enough.



**Primary Care.** Get regular health visits and checkups with virtual primary care. It's like an office visit with a primary care provider (PCP) – without the office. You can even choose to see a network PCP regularly, so you have the same provider taking care of you over time.



**Dermatology.** Get a treatment plan from a board-certified dermatologist. Receive a diagnosis in under 72 hours. No appointment needed. Just upload pictures of your skin, hair, or nail concern.



**Urgent Care.** Get care 24/7 for common health issues, including allergies, COVID-19 symptoms, the flu, sinus infections, and UTIs. Physicians assess your symptoms, provide a treatment plan, and send prescriptions to the pharmacy of your choice when needed.



**Breastfeeding support.** Have an online appointment with a lactation consultant who can provide help with common breastfeeding issues.



Sign up for free today! Available through the Sydney<sup>SM</sup> Health app or Anthem.com.

Apple App Store | Google Play

**Welcome to your Blue View Vision plan!**

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, Target Optical®, and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at the number on the back of your ID card.

| YOUR BLUE VIEW VISION PLAN BENEFITS | IN-NETWORK | OUT-OF-NETWORK       | FREQUENCY                |
|-------------------------------------|------------|----------------------|--------------------------|
| <b>Routine Eye Exam</b>             |            |                      |                          |
| A comprehensive eye examination     | \$15 copay | Up to \$30 allowance | Once every calendar year |

**USING YOUR BLUE VIEW VISION PLAN**

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

**ADDITIONAL SAVINGS ON EYEWEAR AND MORE**

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

**OUT-OF-NETWORK**

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at **anthem.com**, or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

**To Fax:** 866-293-7373  
**To Email:** oonclaims@eyewearspecialoffers.com  
**To Mail:** Blue View Vision  
 Attn: OON Claims  
 P.O. Box 8504  
 Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit **anthem.com** or call us at the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

| OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY  |   | Member Pays          |
|---|---|----------------------|
| <b>Retinal Imaging</b>  | <ul style="list-style-type: none"> <li>At member's option can be performed at time of eye exam</li> </ul>   | Not more than \$39   |
| <b>Eyeglass Frame</b>   | <ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*</li> </ul>  | 35% off retail price |
| <b>Eyeglass Lenses</b><br>Standard plastic material   | <ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> <li>Single Vision \$50</li> <li>Bifocal \$70</li> <li>Trifocal \$105</li> </ul> </li> </ul>   |                      |
| <b>Eyeglass Lens Options and Upgrades</b><br>When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses. | <ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> <li>UV Coating \$15</li> <li>Tint (Solid and Gradient) \$15</li> <li>Standard Scratch-Resistant Coating \$15</li> <li>Standard Polycarbonate \$40</li> <li>Standard Anti-Reflective Coating \$45</li> <li>Standard Progressive Lenses (add-on to Bifocal) \$65</li> <li>Other Add-Ons 20% off retail price</li> </ul> </li> </ul> |                      |
| <b>Conventional Contact Lenses</b><br>(non-disposable type)   | <ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>  | 15% off retail price |

\* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Some of the Blue View Vision participating in-network providers include:



#### ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just log in at [anthem.com](http://anthem.com), select discounts, then Vision, Hearing & Dental.

# Anthem Website Login Guide

EMPLOYEE BOOKLET



## Step 1: Visit Anthem Online

Go to [www.anthem.com](http://www.anthem.com) to access your secure member portal anytime.








## Step 2: Sign In or Register

- Click Member Log In in the upper-right corner.
- New to Anthem? Click Register Now and follow guided prompts. Have ready.
- First-time users will be guided through setup.
- Already registered? Enter your username and password each time you return.



## Step 3: Explore Your Member Tools

-  Find or rate a doctor
-  Request a new ID card
-  Print & a temporary ID card
-  Estimate your prescription benefits
-  And many other helpful features



Anthem Customer Service: 1-833-388-1400

# Dental Insurance

Roanoke County Public Schools offers a dental program through Delta Dental of Virginia.

| Dental Premiums       |                  |              |               |                |
|-----------------------|------------------|--------------|---------------|----------------|
| 12-Month Full-Time*   | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber            | \$16.11          | \$25.38      | \$41.49       | \$8.06         |
| Subscriber + 1 Person | \$35.08          | \$32.38      | \$67.46       | \$17.54        |
| Family                | \$68.65          | \$48.06      | \$116.71      | \$34.33        |
| Family School Couple  | \$48.85          | \$67.86      | \$116.71      | \$24.43        |
| 11-Month Full-Time*   | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber            | \$17.58          | \$27.68      | \$45.26       | \$8.79         |
| Subscriber + 1 Person | \$38.28          | \$35.32      | \$73.60       | \$19.14        |
| Family                | \$74.90          | \$52.42      | \$127.32      | \$37.45        |
| Family School Couple  | \$53.30          | \$74.02      | \$127.32      | \$26.65        |
| 10-Month Full-Time*   | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber            | \$19.32          | \$30.46      | \$49.78       | \$9.66         |
| Subscriber + 1 Person | \$42.10          | \$38.86      | \$80.96       | \$21.05        |
| Family                | \$82.38          | \$57.68      | \$140.06      | \$41.19        |
| Family School Couple  | \$58.62          | \$81.44      | \$140.06      | \$29.31        |

\*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

The chart below is a brief outline of the plan. Please refer to the summary plan description on [www.rcpsbenefits.com/](http://www.rcpsbenefits.com/) for complete plan details.

|   | Delta Dental of Virginia<br>Dental PPO Plus Premier |             |                |
|---|---|-------------|----------------|
|   | PPO   | Premier     | Out-Of-Network |
| <b>Annual Deductible</b>                                  |   |             |                |
| Individual  | \$50  | \$50        | \$50           |
| Family  | \$150   | \$150       | \$150          |
| Waived for Preventive Care                                | Yes   | Yes         | Yes            |
| <b>Annual Maximum</b>                                     |   |             |                |
| Per Person / Family                                       | \$1,500   | \$1,500     | \$1,500        |
| Preventive<br><i>Exams, X-Rays</i>                        | 100%  | 100%        | 100%           |
| Basic<br><i>Simple Extractions,<br/>Endo/Periodontics</i> | 90%   | 80%         | 80%            |
| Major<br><i>Crowns, Bridges, Implants</i>                 | 60%   | 50%         | 50%            |
| <b>Orthodontia</b>  |   |             |                |
| Benefit Percentage  | Not covered   | Not covered | Not covered    |

### Healthy Smile, Healthy You Program

Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the Healthy Smile, Healthy You Program is simple. Visit [www.deltadentalva.com](http://www.deltadentalva.com) to print an enrollment form.

Employees MUST provide documentation to show that their dependents are eligible for the school's dental plans. To search for participating providers, please visit [www.deltadentalva.com](http://www.deltadentalva.com)



# Vision Insurance – Voluntary Stand-Alone Plan

The Roanoke County Public Schools provides an Optional Vision Insurance plan through Anthem. Medical participants receive an Exam Only Vision benefit while the plan below is a more comprehensive Vision plan should employees wish to have coverage for materials (glasses and contacts). An overview of the benefits of this plan is reflected in the chart below. You have many choices when it comes to using your benefits. As an Anthem Vision plan member, you have access to one of the nation’s largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page, select Find a Doctor.

| Voluntary Vision Premiums |                  |              |               |                |
|---------------------------|------------------|--------------|---------------|----------------|
| 12-Month Contracted*      | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber                | \$5.94           | -            | \$5.94        | \$2.97         |
| Subscriber + Child(ren)   | \$10.70          | -            | \$10.70       | \$5.35         |
| Subscriber + Spouse       | \$10.70          | -            | \$10.70       | \$5.35         |
| Family                    | \$17.20          | -            | \$17.20       | \$8.60         |
| 11-Month Contracted*      | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber                | \$6.48           | -            | \$6.48        | \$3.24         |
| Subscriber + Child(ren)   | \$11.68          | -            | \$11.68       | \$5.84         |
| Subscriber + Spouse       | \$11.68          | -            | \$11.68       | \$5.84         |
| Family                    | \$18.76          | -            | \$18.76       | \$9.38         |
| 10-Month Contracted*      | Monthly Employee | Monthly RCPS | Total Premium | Per Pay Period |
| Subscriber                | \$7.12           | -            | \$7.12        | \$3.56         |
| Subscriber + Child(ren)   | \$12.84          | -            | \$12.84       | \$6.42         |
| Subscriber + Spouse       | \$12.84          | -            | \$12.84       | \$6.42         |
| Family                    | \$20.64          | -            | \$20.64       | \$10.32        |

\*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

**Blue View Vision<sup>SM</sup>**  
**FS.A.10.20.150.150**  
**Roanoke Schools**  
**Voluntary Vision**



**Welcome to your Blue View Vision plan!**

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or the Sydney app. You may also call member services for assistance at **1-866-723-0515**.

**Out-of-Network** – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Your vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

| YOUR BLUE VIEW VISION PLAN BENEFITS  | IN-NETWORK   | OUT-OF-NETWORK  | FREQUENCY                       |
|--|--|---|---------------------------------|
| <b>Routine Eye Exam</b>  |  |   |                                 |
| A comprehensive eye examination  | \$10 Copay   | Reimbursed Up To \$30   | Once every 12 months            |
| <b>Eyeglass Frames</b>   |  |   |                                 |
| One pair of eyeglass frames  | \$150 Allowance, then 20% off any remaining balance  | Reimbursed Up To \$45   | Once every 12 months            |
| <b>Eyeglass Lenses (instead of contact lenses)</b>   |  |   |                                 |
| One pair of standard plastic prescription lenses   |  |   |                                 |
| <ul style="list-style-type: none"> <li>• Single vision lenses</li> <li>• Bifocal lenses</li> <li>• Trifocal lenses</li> <li>• Lenticular lenses</li> </ul>   | <ul style="list-style-type: none"> <li>\$20 Copay</li> <li>\$20 Copay</li> <li>\$20 Copay</li> <li>\$20 Copay</li> </ul>   | <ul style="list-style-type: none"> <li>Reimbursed Up To \$25</li> <li>Reimbursed Up To \$40</li> <li>Reimbursed Up To \$55</li> <li>Reimbursed Up To \$125</li> </ul> | Once every 12 months            |
| <b>Eyeglass Lens Enhancements</b>  |  |   |                                 |
| <i>When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost</i>  |  |   |                                 |
| <ul style="list-style-type: none"> <li>• <b>Transitions</b> Lenses (for a child under age 19)</li> <li>• Standard polycarbonate (for a child under age 19)</li> <li>• Factory Scratch Coating</li> </ul>   | <ul style="list-style-type: none"> <li>\$0 Copay</li> <li>\$0 Copay</li> <li>\$0 Copay</li> </ul>  | No allowance when obtained out-of-network   | Same as covered eyeglass lenses |
| <b>Contact Lenses (instead of eyeglass lenses)</b>   |  |   |                                 |
| <i>Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period..</i> |  |   |                                 |
| <ul style="list-style-type: none"> <li>• Elective conventional (non-disposable)<br/>OR</li> <li>• Elective disposable<br/>OR</li> <li>• Non-elective (medically necessary)</li> </ul>  | <ul style="list-style-type: none"> <li>\$150 Allowance, then 15% off any remaining balance</li> <li>\$150 Allowance<br/>(no additional discount)</li> <li>Covered in full</li> </ul> | <ul style="list-style-type: none"> <li>Reimbursed Up To \$105</li> <li>Reimbursed Up To \$105</li> <li>Reimbursed Up To \$210</li> </ul>                              | Once every 12 months            |

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package. .

**EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)**

**Combined Offers.** Not to be combined with any offer, coupon, or in-store advertisement.

**Excess Amounts.** Amounts in excess of covered vision expense.

**Sunglasses.** Plano sunglasses and accompanying frames.

**Safety Glasses.** Safety glasses and accompanying frames.

**Not Specifically Listed.** Services not specifically listed in this plan as covered services.

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

**Orthoptics.** Orthoptics or vision training and any associated supplemental testing

| OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY<br>(Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)   |   | In-Network Member Cost<br>(after any applicable copay) |
|---|---|--|
| <b>Retinal Imaging</b> - at member's option, can be performed at time of eye exam   |   | Not More Than \$39                                     |
| <b>Eyeglass lens upgrades</b><br>When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies. | <ul style="list-style-type: none"> <li>• Transitions lenses (Adults) \$75</li> <li>• Standard Polycarbonate (Adults) \$40</li> <li>• Tint (Solid and Gradient) \$15</li> <li>• UV Coating \$15</li> <li>• Progressive Lenses<sup>1</sup> <ul style="list-style-type: none"> <li>• Standard \$65</li> <li>• Premium Tier 1 \$85</li> <li>• Premium Tier 2 \$95</li> <li>• Premium Tier 3 \$110</li> </ul> </li> <li>• Anti-Reflective Coating<sup>2</sup> <ul style="list-style-type: none"> <li>• Standard \$45</li> <li>• Premium Tier 1 \$57</li> <li>• Premium Tier 2 \$68</li> </ul> </li> <li>• Other Add-ons (i.e. high index lenses, anti-fog coating) 20% off retail price</li> </ul> |  |
| <b>Additional Pairs of Eyeglasses</b><br>Anytime from any Blue View Vision network provider   | <ul style="list-style-type: none"> <li>• Complete Pair 40% off retail price</li> <li>• Eyeglass materials purchased separately 20% off retail price</li> </ul>  |  |
| <b>Eyewear Accessories</b>  | <ul style="list-style-type: none"> <li>• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 20% off retail</li> </ul>  |  |
| <b>Conventional Contact Lenses (non-disposable type)</b>  | <ul style="list-style-type: none"> <li>• Discount applies to materials only 15% off retail price</li> <li>•</li> </ul>  |  |
| <b>Contact lens fit and follow-up</b><br>A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.                               | <ul style="list-style-type: none"> <li>• Standard contact lens fitting<sup>3</sup> Up to \$55</li> <li>• Premium contact lens fitting<sup>4</sup> 10% off retail price</li> </ul>   |  |

<sup>1</sup> Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

<sup>2</sup> Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

<sup>3</sup> Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

<sup>4</sup> Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations. Some of our in-network providers include:



Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at [anthem.com](http://anthem.com), select discounts, then Vision, Hearing & Dental. \* Discounts cannot be used in conjunction with your covered benefits.

**OUT-OF-NETWORK**

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at [anthem.com](http://anthem.com), or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

**TO FAX:** 866-293-7373  
**TO EMAIL:** [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)  
**TO MAIL:** Blue View Vision  
 Attn: OON Claims  
 P.O. Box 8504  
 Mason, OH 45040-7111



## Employee Wellness Program

The **wellness incentive** will now determine whether you receive employer funds for your **Health Reimbursement Account (HRA)** or **Health Savings Account (HSA)**. Reduced insurance rates are no longer offered.

### Who Qualifies for the Wellness Incentive?

- Employees enrolled in the KeyCare 1000, Healthkeepers HMO 2000, and Healthkeepers HMO 3400 plan.
- **To maintain eligibility for the incentive**, you must complete an **annual exam** with your **primary care physician**.

### Does this exam cost anything?

- No. Preventive care visits are **covered at 100%** by Anthem.

### How Do We Track Compliance?

- **Anthem** will provide a **monthly report** indicating which employees have completed a **preventive care visit** in the previous month.

We encourage all employees to take advantage of this benefit and prioritize their health. Completing your annual exam not only supports your well-being but also ensures you receive available employer contributions. If you have any questions or need additional details, please contact **Tracy Bandy, HR Benefits Manager**, at [tjbandy@rcps.us](mailto:tjbandy@rcps.us).

**Your health matters! Stay well, stay informed.**

# Health Savings Accounts

When you enroll in the new High Deductible Health Plan (HDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to a Health Savings Account (HSA). An HSA is a tax-advantaged bank account that you own for the purpose of paying for eligible out of pocket expenses for you/or your eligible dependents.

The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” provision; your balance carries over year to year! You can only contribute when enrolled in the HDHP plan – with RCPS this is the **Anthem HealthKeepers 3400 HMO plan**.

**If you choose to participate in the RCPS Wellness Program and complete your free Preventive Annual Physical Exam, RCPS will contribute up to \$1,200 to your HSA as an individual and \$2,400 if you cover dependents!**

## Tax Advantages

- Money deposited into an HSA is exempt from federal income taxes – this helps to lower your overall taxable income.
- Interest in your account grows tax free.
- You do not pay taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes & penalties will apply).
- You also have the choice of investment opportunities which earn competitive interest rates, so your unused funds can grow over time.

## Am I Eligible to Contribute to an HSA?

- You must be enrolled in a High Deductible Health Plan (HDHP).
- You cannot be covered under another health insurance plan – including Medicare or Tricare. (Other health insurance does not include dental, vision, or workplace voluntary benefits).
- You cannot be claimed as dependent on someone else’s tax return.
- You are not eligible if you participate in a healthcare Flexible Spending Account.

## IRS Annual Limits

Since an HSA is a tax-advantaged account, it is monitored by the IRS, and they set annual contribution limits each calendar year. The 2026 contribution limits are listed below:

- **2026 Calendar Year:**
  - Individual: **\$4,400**
  - Family: **\$8,750**
  - 55 and older catch-up contribution: additional **\$1,000**

**Please note that the IRS Calendar Year contribution limits include the Wellness incentive that RCPS deposits into your HSA!**

**Visit the HSA Store for more information on eligible expenses for your HSA!**

[HSA Store](#)

# HSA Frequently Asked Questions

**Q: Will the School Board fund this money for the employee?**

A: Yes, the School Board funds up to \$1,200 for a single plan and \$2,400 for a plan with any additional family members **if you participate in the Wellness Program and complete your Annual Preventive Exam**. This amount will be pro-rated for mid-year new hires or mid-year qualifying events. You may also choose to contribute pre-tax dollars through payroll deduction to your HSA up to \$4,400 as an individual and \$8,750 if you cover dependents for the 2026 calendar year.

**Q: Am I eligible to participate in the HSA option if I am part-time?**

A: Yes, all full and part time contracted employees are eligible to participate in the HSA plan option and receive up to \$1,200/\$2,400 contributed to their HSA.

**Q: Am I eligible to participate in the HSA option if I am already retired or will retire as of June 30, 2026?**

A: Employees participating in this plan will be eligible to retain this plan after retirement, but there will be no further contributions to the HSA account from RCPS.

**Q: Can employees contribute additional HSA funds each year, beyond the School Board contribution amounts?**

A: Yes, when you choose to enroll in the new HealthKeepers 3400 HMO plan and open an HSA (see that section) you can contribute up to \$4,400 or \$8,750 if you cover dependents to offset out-of-pocket health expenses.

**Q: If I elect the new HSA plan, can I also have the HRA and/or FSA?**

A: No, you are not eligible to participate in the HRA or the Healthcare FSA (**but you can still participate in the Dependent Care FSA**), if you are enrolled in the new HealthKeepers \$3,400 plan and are contributing to your HSA.

**Q: Can I pay for eligible medical/Rx, dental and/or vision expenses for my spouse or dependent(s) who is not covered under my medical plan?**

A: Yes, you can pay for out-of-pocket eligible health care expenses for yourself, spouse and all of your dependents for healthcare services incurred year after year.

**Q: Will the HSA funds roll over each year if any portion goes unused or is it “use it or lose it”?**

A: The full amount of unused funds in the HSA will continue to roll over each year into the next coverage period – there is no “use it or

lose it” provision with an HSA. You can even invest the funds in your HSA and any interest you earn is not taxed.

**Q: Will there be a time limit on when I will have to spend the money and/or turn in receipts for reimbursement to my HSA?**

A: No, you can continue to build your HSA funds year after year to use on future out-of-pocket health expenses. You just have to be mindful of the IRS Calendar Year contribution limits (these are set by the IRS and change from year to year).

**Q: What happens to the funds in my HSA if I terminate my employment?**

A: The funds in your HSA (including any contributions made by RCPS when you participate in the Wellness Program) are yours to take with you. If you elect COBRA continuation coverage upon termination, you may use the funds in your HSA for this.

**Q: What happens to the funds in my HSA if I retire?**

A: You will have continued access to any unused funds remaining in your HSA account at the time of retirement that can be used for qualified medical expenses if you are enrolled in any of the Anthem plans offered by RCPS. If you become Medicare eligible, you can even use your HSA funds towards Medicare premiums and out-of-pocket health expenses. There will be no additional HSA contributions by RCPS after you retire and if you choose to enroll in Medicare when eligible, you can no longer contribute to your HSA.

**Q: If I terminate my employment or retire, will I be able to cash out the remaining balance in my HSA and pay the tax penalties to use the funds for expenses other than healthcare?**

A: Yes, you can cash out the HSA account. This account is your own personal savings account. You can continue to use to towards out-of-pocket health expenses and pay no penalties or tax. Or, you can withdraw the funds and use them as you wish but pay any penalty and income tax.

**Q: If I pass away, what will happen to my funds in the HSA?**

A: Since an HSA is your own personal savings account, it will become a part of your estate just like your other personal bank accounts.

**Q: Do I need to have receipts for all distributions from my HSA ?**

A: Yes, you must keep receipts and accurate records when you use your HSA funds in the unlikely event that you are ever audited. You do not need to send in these receipts/records when you do your taxes, just keep them with your tax files.

# Health Reimbursement Accounts

Your Health Reimbursement Account (HRA) is administered through Empower.

## What is the Health Reimbursement Arrangement (HRA)?

The Health Reimbursement Arrangement is an account that is funded and owned by RCPS. You may use the funds in the HRA to reimburse you for qualified medical care expenses that have not been reimbursed by the RCPS' health plans.

To be eligible for an HRA, the employee must be enrolled in either the traditional \$1,000 or \$2,000 Traditional medical plans and participate in the Wellness Program. Those enrolled in employee coverage will receive a \$500 contribution to their HRA, while those enrolled in other coverage tiers will receive a \$1,000 contribution. While the HRA funds do rollover from year to year, there is a maximum rollover limit of \$25,000. See the HRA FAQs page for more information.



# HRA Frequently Asked Questions

**Q: Will the School Board fund this money for the employee?**

A: Yes, the School Board funds up to \$500 for a single plan and \$1,000 for a plan with any additional family members **if you participate in the Wellness Program and complete your Annual Preventive Exam**. This amount will be pro-rated for mid-year new hires or mid-year qualifying events.

**Q: Am I eligible to participate in the HRA option if I am part-time?**

A: Yes, all full and part time contracted employees are eligible to participate in the HRA and receive the Wellness incentive of \$500/\$1,000 to use on medical expenses.

**Q: Am I eligible to participate in the HRA option if I am already retired or will retire as of June 30, 2026?**

A: Employees participating in this plan will be eligible to retain this plan after retirement, but there will be no further contributions to the HRA account.

**Q: Can employees contribute additional HRA funds each year, beyond the School Board contribution amounts?**

A: No, the employee cannot contribute additional funds into the HRA. The employee can, however, participate in Flexible Benefits (see that section) and contribute up to \$3,400 for health expenses and \$7,500 for Dependent Care. Or choose to enroll in the new HealthKeepers 3400 HMO plan and open an HSA (see that section) to contribute up to \$4,400 or \$8,750 if you cover dependents to offset out-of-pocket health expenses.

**Q: If I elect the HRA plan, and I also have an FSA (Flexible Benefits) plan, from which account will my claims come from first?**

A: Money will be taken from your FSA first, then from your HRA.

**Q: If I elect the new HSA plan, can I also have the HRA?**

A: No, you are not eligible to participate in the HRA or the Healthcare FSA (but you can still participate in the Dependent Care FSA), if you are enrolled in the new HealthKeepers \$3,400 plan and are contributing to your HSA.

**Q: Can I pay for eligible medical/Rx, dental and/or vision expenses for my spouse or dependent(s) who is not covered under my medical plan?**

A: Yes, you can pay for out-of-pocket eligible health care expenses for yourself, spouse and all of your dependents for healthcare services incurred during the plan year and while you are an active participant.

**Q: Will the HRA funds roll over each year if any portion goes unused or is it “use it or lose it”?**

A: The full amount of unused funds in the HRA will continue to roll over each year into the next coverage period as long as you are an active employee, enrolled in either the KeyCare \$1,000, or HK \$2,000 plan and do not exceed the maximum amount of \$25,000.

**Q: Will there be a time limit on when I will have to spend the money and/or turn in receipts for reimbursement to my HRA?**

A: Yes, all receipts must be dated within the plan year dates (July 1-June 30) and submitted for reimbursement within 90 days of the plan year end. Funds not spent during the plan year will rollover to the next coverage period.

**Q: What happens to the funds in my HRA if I terminate my employment?**

A: You may submit reimbursement requests for any allowable medical expense incurred up to your termination date and be reimbursed from your HRA if you submit reimbursement requests within 90 days of your last day of work. If you elect COBRA continuation coverage upon termination and pay your monthly COBRA premium, you will have continued access to the HRA funds for up to 18 months after termination. Otherwise, the funds revert back to the employer.

**Q: What happens to the funds in my HRA if I retire?**

A: You will have continued access to any unused funds remaining in your HRA account at the time of retirement that can be used for allowable medical expenses as long as you are on either KeyCare \$1,000 plan or HealthKeepers \$2,000 plan with RCPS. There will be no additional HRA contributions by your employer after you retire.

**Q: If I terminate my employment or retire, will I be able to cash out the remaining balance in my HRA and pay the tax penalties to use the funds for expenses other than healthcare?**

A: No, you cannot cash out the HRA account. The HRA is employer funded and remains the property of the employer unless you use the funds for allowable medical expenses incurred within the plan year.

**Q: If I pass away, what will happen to my funds in the HRA?**

A: The funds become available to any surviving spouse and children. They may submit reimbursement requests within 6 months for any allowable medical expense incurred up to your date of death and be reimbursed from the HRA. If they elect COBRA continuation coverage upon your death and pay their monthly COBRA premium, they will have continued access to the HRA funds for up to 36 months after your date of death. Otherwise, the funds revert back to the employer.

**Q: Will I have to complete and submit paper claim reimbursements, or will I have a debit card option similar to Flexible Benefits?**

A: All new HRA members will be issued a Benefits Card that is good for a three-year period. If you do not want to use the card option, you will have to call Empower and request to “deactivate” the card. You will then be required to provide your personal banking information so you can receive direct deposit of your reimbursements from your HRA account.

(Anyone who participates in both the HRA and the FSA will have the total amount of both accounts loaded on the same card. Example: If you elect the KeyCare 1000 or HK 2000 plan/HRA single plan option, your Benefit Card could have \$3,550 loaded on the card as of July 1. (\$500 HRA contribution from the School Board + \$3,300, the maximum contribution you could choose with Flexible Benefits through the FSA.) **Note: You cannot use your debit card for previous plan year claims/expenses, you must file manual claims but can continue to use your debit card for current year expenses.**

**Q: Do I need to have receipts for all claims submitted to the HRA for reimbursement?**

A: Yes, you must keep receipts, even if you use the debit card feature, as the third-party administrator routinely requests supporting documentation for medical services charged to your debit card.

# Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with Empower allows you to set aside **pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars.** The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

## How an FSA works:

- Choose a specific amount of money to contribute each pay period, **pre-tax**, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Employees can go to the [FSA Store](#) to obtain a list of eligible expenses and even shop!

## Types of FSAs:

**HealthCare FSA:** As an active participant you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all of your tax dependents that are incurred during your Plan Year. Eligible expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or of the purpose of affecting any structure or function for the body.

**Dependent Care FSA:** This account allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are considered care of an eligible dependent so that you and your spouse can go to work or school full-time. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you can claim as dependents on your taxes.

**Note: You can still participate in the Dependent Care FSA even if you enrolled in the new HealthKeepers 3400 HMO plan with the HSA!**

## Important rules to keep in mind:

- The IRS has a strict “use it or lose it” rule. Your plan has a \$680 rollover provision. However, if you do not use the full amount in your FSA, you will lose any remaining funds that are in excess of \$680.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

| MAXIMUM CALENDAR YEAR ANNUAL ELECTION |         |
|---------------------------------------|---------|
| Health Care FSA                       | \$3,400 |
| Dependent Care FSA                    | \$7,500 |

## Additional Things to Note About the HealthCare FSA:

**The HealthCare FSA is a pre-funded account.** This means that your full annual election is available on the first day of the Plan Year. You can submit a claim for medical expenses exceeding your current contribution amount and be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

## Obtaining a Reimbursement from your HealthCare Account:

To obtain a reimbursement from your HealthCare Account, you must complete a Claim Form. You must attach a receipt, bill, or an Explanation of Benefits (EOB) from your service provider. Please see the Claims Sections for more information.

**NOTE:** To be eligible for reimbursement through the HealthCare Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care.

## How the Flexible Benefit Plan Works

|  | Without<br>FSA | With<br>FSA |
|--|----------------|-------------|
| <b>Gross Monthly Income</b>                      | \$2,500.00     | \$2,500.00  |
| Eligible Pre-Tax Employer Medical Insurance      | \$0.00         | \$200.00    |
| Eligible Pre-Tax Medical Expenses <b>Taxable</b> | \$0.00         | \$100.00    |
| <b>Income</b>                                    | \$2,500.00     | \$2,200.00  |
| Federal Tax (15%)                                | \$375.00       | \$330.00    |
| State Tax (5.75%)                                | \$143.75       | \$126.50    |
| FICA Tax (7.65%)                                 | \$191.25       | \$168.30    |
| After-Tax Employer Medical Insurance After-      | \$200.00       | \$0.00      |
| Tax Medical Expenses                             | \$100.00       | \$0.00      |
| <b>Monthly Spendable Income</b>                  | \$1,490.00     | \$1,575.20  |

*By taking advantage of the Flexible Benefit Plan, this employee was able to increase his/her spendable income by \$85.20 every month! This means an annual tax savings of \$1,022.40. Remember, with the Flexible Benefit Plan, the better you plan, the more you save!*

## Additional Things to Note About the Dependent Care FSA:

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars. **You are still eligible to participate in this FSA even if you are enrolled in the HDHP HealthKeepers 3400 HMO plan and are contributing to your Health Savings Account!**

### Eligible Dependent:

- A child under 13 who qualifies as a dependent on your Federal Income Taxes.
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self-care.



**The Dependent Care Account is NOT a pre-funded account.** This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Empower. You will be automatically reimbursed as additional deductions are deposited into your account.

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form and you must attach a receipt from the service provider.

# Short-Term and Long-Term Disability Insurance

## VRS Hybrid Only

### Plan eligibility

If you were hired and a member of the VRS Hybrid Retirement Plan on or after January 1, 2014, and met the disability plan member definition and active work requirement, you are covered under VACORP Hybrid Disability Plan offered by Anthem Life as addressed below. You are a member if you are a U.S. or Canadian citizen or resident and are actively at work at least the minimum hours per week required by your employer for coverage and are an employee of Roanoke County Public Schools. Members exclude a temporary or seasonal employee or a leased employee or independent contractor.

If you were hired before January 1, 2014, and elected to transfer to the VRS Hybrid Retirement Plan from the VRS Plan 1 or the VRS Plan 2, your coverage in the plan and in the hybrid disability plan was effective July 1, 2014, assuming you met the member and active work requirements. If you left employment and took a refund of your Plan 1 or Plan 2 member contributions and interest or withdrew your full account balance from an ORP authorized or administered by VRS, you will be rehired under the Hybrid Retirement Plan if you return to a position covered under the plan.

### Short-Term Disability Benefits Overview

Short Term Disability (STD) helps to provide financial protection with a bi-weekly benefit in the event of a covered disability.

- Elimination/Waiting Period before benefits begin:
  - The STD benefit is payable after the employee has been continuously disabled for 7 continuous calendar days.
- Maximum Benefit Period is 125 business days.
- Benefit Amount:
  - The disability benefit is a percentage of pre-disability wages that is determined by the months of continuous service with Roanoke County Public Schools and shown in the charts below.
- The School covers all costs associated with the STD plan.

Non-Occupational

| Months of Continuous Service | Workdays at 100% Income Replacement | Workdays at 80% Income Replacement | Workdays at 60% Income Replacement |
|------------------------------|-------------------------------------|------------------------------------|------------------------------------|
| 0-12                         | 0                                   | 0                                  | 0                                  |
| 13-59                        | 0                                   | 0                                  | 125                                |
| 60-119                       | 25                                  | 25                                 | 75                                 |
| 120-179                      | 25                                  | 50                                 | 50                                 |
| 180+                         | 25                                  | 75                                 | 25                                 |

Work-Related

| Months of Continuous Service | Workdays at 100% Income Replacement | Workdays at 80% Income Replacement | Workdays at 60% Income Replacement |
|------------------------------|-------------------------------------|------------------------------------|------------------------------------|
| Fewer than 60                | 0                                   | 0                                  | 125                                |
| 120+                         | 85                                  | 40                                 | 0                                  |
| 120-179                      | 25                                  | 50                                 | 50                                 |
| 180+                         | 25                                  | 75                                 | 25                                 |

## Long-Term Disability Benefits Overview

Long Term Disability (LTD) helps to provide financial protection with a monthly benefit in the event of a covered disability.

- The benefit waiting period is 7 calendar days plus 125 contract workdays.
- Benefits paid under LTD are taxable
- A policy summary is available on our [www.rcpsbenefits.com/](http://www.rcpsbenefits.com/) for more detailed information on this plan.

## Filing a Disability Claim

In the event that you need to file a disability claim, the first thing you must do is notify RCPS Human Resources Dept. They will provide the steps and contact information to Anthem to file your claim. Please note that if you are approved for a Short-Term Disability claim through Anthem, you will not have to file a Long-Term Disability claim, should this be applicable to your situation.



## VRS Retirement

Roanoke County Public Schools provides retirement benefits through the Virginia Retirement System (VRS), offering three plan options: Plan 1, Plan 2, and the Hybrid Plan. The plan you are eligible for is based on your hire date and any previous service under VRS. All employees are required to contribute 5% of their salary to VRS as a mandatory retirement contribution. Additionally, Hybrid Plan members can receive a match of up to 2.5% if they participate in the Hybrid DCP account.

Create a VRS account to explore your plan details and available benefits. Contact Tracey Epperly, HR VRS Manager for more information at [tepperly@rcps.us](mailto:tepperly@rcps.us) or at 540-562-3900.

# Your guide to navigating your benefits

Explore  
**myVRS**

## Register your online myVRS account today!

**myVRS**

- Secure Login
- Retirement Planner
- Benefit Estimator
- Manage Beneficiaries
- Request Refund  
(when you leave employment)
- Purchase Prior Service
- Retire Online
  - Set up direct deposit
  - Claim health insurance credit

**myVRS** Powered by Enrich  
FINANCIAL WELLNESS

- Articles, Videos and Webinars
- Calculators
- Educational Games
- Budgeting Tools

PLUS personalized content exclusive to members through your myVRS account log-in:

- Interactive Courses
- Action Plans
- Money Mindfulness

[varetire.org/myVRS](https://varetire.org/myVRS)  
HELPING YOU PLAN FOR TOMORROW, TODAY

**VRS** Virginia  
Retirement  
System®

# Helping You Plan for Tomorrow, Today

As a VRS member, you have access to a secure online system to monitor your retirement savings, learn about your VRS benefits and plan for the future.

## Your personal myVRS account offers:

### ✓ VRS Benefits Summary

- Check your retirement eligibility dates and member account balance.
- Discover your other VRS benefits.

### ✓ myVRS Retirement Planner

- Project your income and expenses in retirement.
- Set your retirement income goal and make a plan.

### ✓ myVRS Benefit Estimator

- Select different retirement dates and benefit payout options.
- Save your estimates for future reference.

### ✓ myVRS Financial Wellness

- Watch a short video about student loan repayment or play a game of financial football.
- Take the Financial Health Assessment and Money Personality mini-courses.



**Log in or register today for myVRS: <https://myVRS.varetire.org>**

myVRS HOURS OF OPERATION:

Monday-Saturday, 7 a.m.-11:30 p.m.

Sunday, 8:30 a.m.-11:30 p.m.

# Basic Group Life Insurance and Optional Group Life Insurance

## Basic Group Life Insurance

Full-time employees are enrolled in the Basic Group Life Insurance coverage from their first day of employment. VRS administers the Basic Group Life Insurance coverage which is underwritten by Securian Financial (formerly Minnesota Life Insurance Company). Roanoke County Public Schools pays 100% of the premiums for this benefit.

Your coverage includes a natural death benefit, equal to your compensation, rounded to the next highest thousand and then doubled; an accidental death benefit, double the natural death benefit; an accidental dismemberment benefit; a safety belt benefit; a repatriation benefit; a felonious assault benefit; and an accelerated death benefit. Death benefits are paid to your beneficiary.

After you retire with an unreduced or reduced retirement benefit, you receive some Basic Group Life Insurance coverage at no cost to you, provided you meet the eligibility requirements under your retirement plan. Your coverage begins to reduce on January 1 following one calendar year after your employment ends. Your benefits will begin to reduce 25% each January 1 until the benefit reaches 25% of the total life insurance benefit value at the time your employment ends. If you are eligible for retirement when your employment ends, but defer retirement, and you do not take a refund of your member contributions and interest, some basic life insurance benefits will continue. Your benefits will begin to reduce 25% each January 1 following the same reduction schedule reflected above for someone who retires. If you have at least 30 years of creditable service, your coverage cannot reduce below an \$8,000 minimum established in 2015. This minimum will be increased annually based on the VRS Plan 2 cost-of-living adjustment calculation.

## Optional Group Life Insurance

If covered under the Basic Group Life Insurance Program, you may be eligible to purchase additional life insurance for yourself, your spouse and dependent children through the Optional Group Life Insurance Program. You pay the premiums for this additional coverage through payroll deductions. If you are enrolled in this program, you may continue a portion of your coverage into retirement. You, as well as your spouse and dependent children if enrolled, must have been continuously covered during the 60 months preceding your retirement date to continue coverage. Accidental death and dismemberment coverage ends upon retirement. Optional life insurance amounts will reduce by 25% based on your age, beginning with your normal retirement age under your plan; coverage ends at age 80. You must elect to continue your coverage within 31 days of your retirement date; after 31 days, it will not be available.

You, as well as your spouse and dependent children, if enrolled, can convert your coverage to an individual policy without proof of good health within 31 days of the last day of the month in which you leave your position. Proof of good health will be required after 31 days. You will be billed for the premiums.

For more information on your VRS Basic Group Life Insurance and Optional Group Life Insurance benefits go to the VRS website at [www.varetire.org](http://www.varetire.org)



# Retirement Savings Plans

Participating in a supplemental retirement savings plan allows employees to set aside additional funds for retirement (eligibility requirements must be met). These contributions are employee-funded and can be made through payroll deductions.

Roanoke County Public Schools offers both a 403(b) and a 457 Retirement Savings Plan through Empower. These plans are separate from your benefits under the Virginia Retirement System, and contributions can be made on either a pretax or post-tax basis. You may enroll, make changes, or discontinue participation at any time throughout the year.

All Roanoke County School employees are eligible to participate in the Empower 403(b) plan, while only contracted employees are eligible for the 457 plan. RCPS provides a match of up to \$600 per year for contracted employees participating in the 403(b) plan. For more information, contact Tracey Epperly, HR VRS Manager at [tepperly@rcps.us](mailto:tepperly@rcps.us) or at 540-562-3900.

For more information, visit our website or contact our vendor/agent directly:



[www.empower.com/participant](http://www.empower.com/participant)

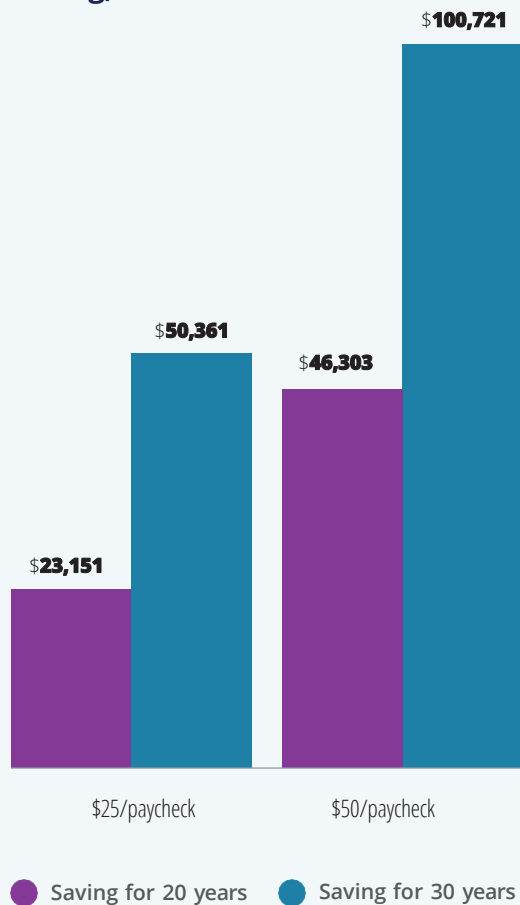
Ben Dickinson  
Retirement Plan Advisor  
Empower Retirement  
[benjamin.dickinson@empower.com](mailto:benjamin.dickinson@empower.com)  
Phone: 865-431-1489  
Client Services: 800-701-8255

\*\*All funds, including target date funds are subject to risk and are not guaranteed.



# Why you should start saving now

## The sooner you start saving, the better<sup>1</sup>



## How much should I save?

According to 74% of Americans,

**8%**

saving for retirement is the most common financial goal, and the average saving rate is 8%.<sup>2</sup>

If you can't swing 8%, just get started saving at 2-4%. Your future self will thank you.

## Tax breaks

Pretax contributions reduce your taxable income — you'll save for tomorrow and also save today.<sup>3</sup>

| \$30,000 Income      | Saving | Not saving |
|----------------------|--------|------------|
| Saved on taxes       | \$180  | \$0        |
| Saved for retirement | \$1200 | \$0        |
| Your contribution    | 4%     | 0%         |

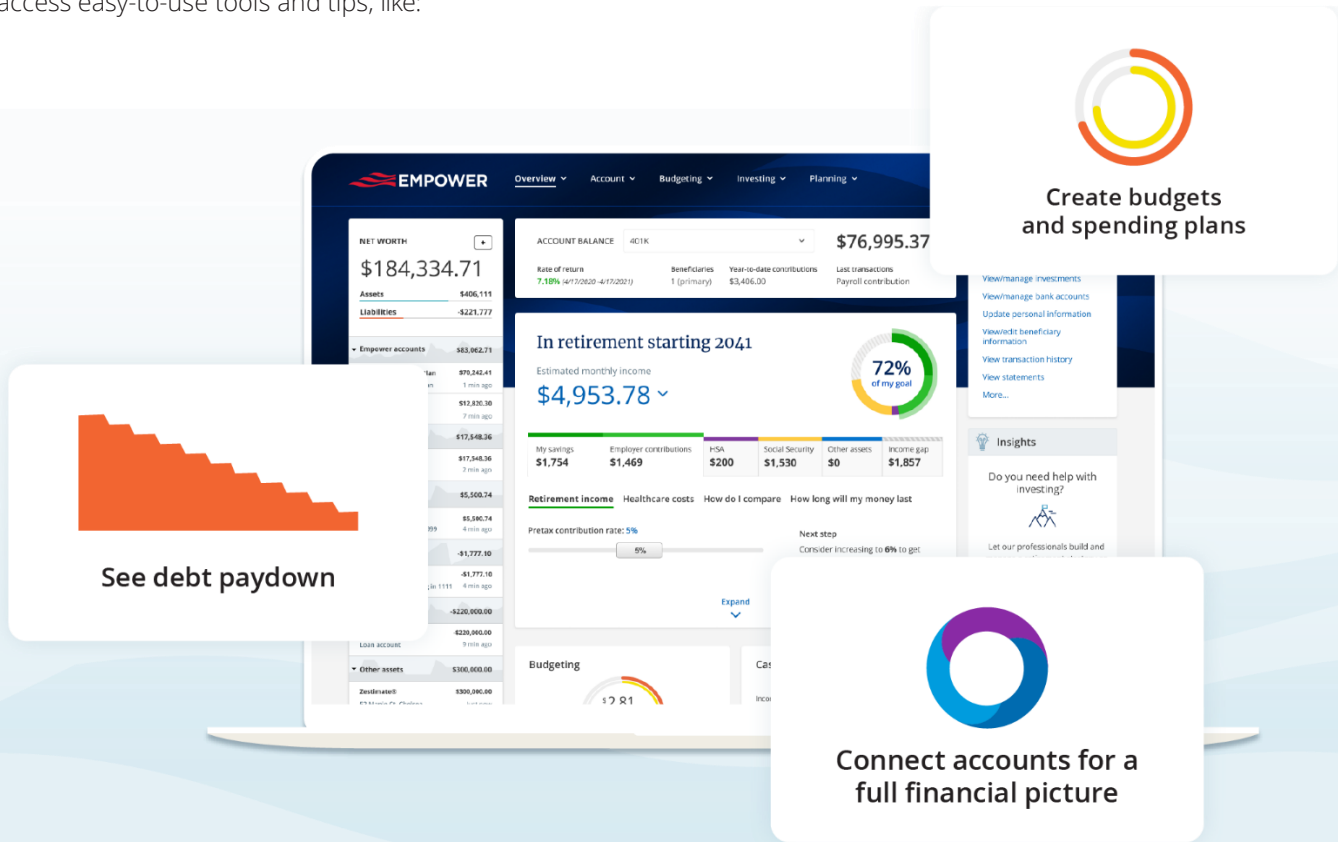
FOR ILLUSTRATIVE PURPOSES ONLY.



➤ Visit [learningfromempower.com](http://learningfromempower.com) to access helpful information, videos, calculators, and more. Scan this code with your camera to go there.

# Get some help with your finances

Most people have questions about their financial health, including how to fit in saving for retirement. Log in to your account at [empowermyretirement.com](https://empowermyretirement.com) to access easy-to-use tools and tips, like:



The image shows a laptop displaying the Empower retirement account dashboard. Three callout boxes are overlaid on the screen:

- See debt paydown:** A callout box with an orange bar chart showing a downward trend, indicating debt reduction.
- Create budgets and spending plans:** A callout box with a circular icon, pointing to the budgeting section of the dashboard.
- Connect accounts for a full financial picture:** A callout box with a circular icon, pointing to the account management section.

The dashboard itself displays a net worth of \$184,334.71, an account balance of \$76,995.37, and a retirement income projection of \$4,953.78 per month starting in 2041. It also shows various asset and liability categories, a retirement progress gauge at 72% of goal, and a budgeting section.

FOR ILLUSTRATIVE PURPOSES ONLY.

1 This hypothetical illustration is not intended as a projection or prediction of future investment results, nor is it intended as financial planning or investment advice. It assumes a 6% annual rate of return over 24 pay periods and reinvestment of earnings with no withdrawals. Rates of return may vary. The illustration does not reflect any associated charges, expenses, or fees. The tax-deferred accumulation shown would be reduced if these fees were deducted.

2 Empower, "Empowering America's Financial Journey," November 2022. The study is based on the analysis of 5.3 million active participants from primarily corporate 401(k) plans with Empower as the recordkeeper and a survey of 2,511 working Americans between the ages of 18 and 70 conducted in August 2023.

3 This is a hypothetical illustration that assumes 15% federal tax rate. State and local taxes not included. Your salary, contribution rate, and tax bracket may vary.

Investing involves risk, including possible loss of principal.

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Unless otherwise noted: Not a Deposit | Not FDIC Insured | Not Bank Guaranteed | Funds May Lose Value | Not Insured by Any Federal Government Agency

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

MAINSTREAM MENTAL HEALTH SERVICES



## Confidential Mental Health Assistance

Access to guidance and counseling with licensed clinicians to assist with concerns such as stress, anxiety, depression, grief, substance abuse, and relationship conflicts. Support options include in-person and telehealth referrals.



## Stress Management & Enhanced Being

Learn to eliminate the chronic negative effects of stress and enhance personal life satisfaction with actionable tools and coaching.

## Life Management Solutions

Help explore resources for everyday concerns including child and eldercare, legal, wellness support groups, and transportation.

**For more info, contact us:**  
(540) 966-5808

**after hours email:**  
[cthepsimuong@mainstreammh.com](mailto:cthepsimuong@mainstreammh.com)

**Offices located in:**  
Roanoke, Dublin, and Blairs

# Contact Information

We're excited to announce a new partnership designed to make your benefits experience smoother, clearer, and more convenient than ever! Innovative Insurance Group (IIG) will be our go to partner for benefit guidance, enrollment support, and ongoing assistance. During Open Enrollment, the experts at IIG will be available to help you understand your benefit options, compare plans, and make confident choices. Throughout the year, IIG will continue to support you with customer service and claims assistance.

- ENROLLMENT CALL CENTER 888-605-3003
- CUSTOMER SERVICE 888-605-3003
- customerservice@thinkinnovative.net

|   | Carrier                           | Phone Number     | Website   |
|---|-----------------------------------|------------------|---|
| Medical   | Anthem Blue Cross and Blue Shield | 1-833-388-1400   | <a href="http://www.anthem.com">www.anthem.com</a>  |
| Prescription  | Anthem                            | 1-833-419-0530   | <a href="http://www.anthem.com">www.anthem.com</a>  |
| Dental  | Delta Dental Insurance Company    | 1-800-237-6060   | <a href="http://www.deltadentalva.com">www.deltadentalva.com</a>  |
| Vision  | Anthem                            | 866-723-0515     | <a href="http://www.anthem.com">www.anthem.com</a>  |
| Short Term Disability (STD)   | The Standard                      | Contact HR Dept. | <a href="https://app.standard.com/benefits/employee/soc/">https://app.standard.com/benefits/employee/soc/</a> |
| Long Term Disability (LTD)  | The Standard                      | Contact HR Dept. | <a href="https://app.standard.com/benefits/employee/soc/">https://app.standard.com/benefits/employee/soc/</a> |
| Health Reimbursement Account<br>Flexible Spending Accounts<br>Health Savings Accounts | Empower                           | 1-855-756-4738   | <a href="http://empowermyretirement.com">empowermyretirement.com</a>  |
| Employee Assistance Program   | Mainstream                        | 1-540-966-5808   | <a href="http://www.mainstreammh.com">www.mainstreammh.com</a>  |
| Long Term Care  | Genworth                          | 1-866-859-6060   | <a href="#">Group LTC - Login</a>   |
| Deferred Compensation<br>(403(b) and 457)   | Empower                           | 1-800-701-8255   | <a href="http://www.empower-retirement.com/participant">www.empower-retirement.com/participant</a>            |
| Retirement  | VRS                               | 1-888-827-3847   | <a href="http://www.varetire.org">www.varetire.org</a>  |
| Basic Group Life  | Securian                          | 1-800-441-2258   | <a href="http://www.varetire.org">www.varetire.org</a>  |
| Optional Group Life   | Securian                          | 1-800-441-2258   | <a href="http://www.varetire.org">www.varetire.org</a>  |

**Please contact Human Resources to complete any changes to your benefits that are not related to your Initial or Annual enrollment.**

This brochure summarizes the benefit plans that are available to Roanoke County Public Schools eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

# HEALTH PLAN COMPLIANCE NOTICES

Roanoke County Public Schools

4/15/2026

Provided by: Innovative Insurance Group

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Notice of Patient Protections

Notice of Privacy Practices

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Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice

WHCRA Notice

## ADA Notice Regarding Wellness Program

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The Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). If you choose to participate in the Wellness Program, you will also be asked to complete an annual physical.

Employees who choose to participate in the wellness program will receive an incentive of employer contributions to your HRA or HSA. Although you are not required to complete the HRA, only employees who do so will receive employer contributions to your HRA or HSA.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Tracy Bandy at 5937 Cove Road, , Roanoke, VA 24019, (540) 540-3900 x 10146, [tjbandy@rcps.us](mailto:tjbandy@rcps.us).

### Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Roanoke County Public Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, Roanoke County Public Schools will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Health and Wellness Center staff in order to provide you with services under the wellness program.

All medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Tracy Bandy

5937 Cove Road

Roanoke, VA 24019

## 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](http://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](http://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](http://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 January 31, 2026. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid  | ALASKA – Medicaid   |
|---|---|
| Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a><br>Phone: 1-855-692-5447   | The AK Health Insurance Premium Payment Program<br>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a><br>Phone: 1-866-251-4861<br>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a><br>Medicaid Eligibility:<br><a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a> |
| ARKANSAS – Medicaid   | CALIFORNIA – Medicaid   |
| Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a><br>Phone: 1-855-MyARHIPP (855-692-7447)  | Health Insurance Premium Payment (HIPP) Program Website:<br><a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a><br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>  |
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)  | FLORIDA – Medicaid  |
| Health First Colorado Website:<br><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a><br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a><br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a><br>HIBI Customer Service: 1-855-692-6442 | Website:<br><a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a><br>Phone: 1-877-357-3268  |

| GEORGIA – Medicaid  | INDIANA – Medicaid   |
|---|--|
| <p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a><br/>           Phone: 678-564-1162, Press 1<br/>           GA CHIPRA Website:<br/> <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a><br/>           Phone: 678-564-1162, Press 2</p>              | <p>Health Insurance Premium Payment Program<br/>           All other Medicaid<br/>           Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a><br/> <a href="http://www.in.gov/fssa/dftr/">http://www.in.gov/fssa/dftr/</a><br/>           Family and Social Services Administration<br/>           Phone: 1-800-403-0864<br/>           Member Services Phone: 1-800-457-4584</p>  |
| IOWA – Medicaid and CHIP (Hawki)  | KANSAS – Medicaid  |
| <p>Medicaid Website:<br/> <a href="https://hhs.iowa.gov/programs/welcome-iowa-medicaid">https://hhs.iowa.gov/programs/welcome-iowa-medicaid</a><br/>           Medicaid Phone: 1-800-338-8366<br/>           Hawki Website:<br/> <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a><br/>           Hawki Phone: 1-800-257-8563<br/>           HIPP Website: <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a><br/>           HIPP Phone: 1-888-346-9562</p>   | <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a><br/>           Phone: 1-800-792-4884<br/>           HIPP Phone: 1-800-967-4660</p>   |
| KENTUCKY – Medicaid   | LOUISIANA – Medicaid   |
| <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br/> <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br/>           Phone: 1-855-459-6328<br/>           Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a><br/>           KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a><br/>           Phone: 1-877-524-4718<br/>           Kentucky Medicaid Website:<br/> <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p> | <p>Louisiana Medicaid Website:<br/> <a href="https://www.ldh.la.gov/healthy-louisiana">https://www.ldh.la.gov/healthy-louisiana</a><br/>           Medicaid Customer Service Line: 1-888-342-6207<br/>           Louisiana Medicaid email: <a href="mailto:healthy@la.gov">healthy@la.gov</a><br/>           Louisiana Health Insurance Premium Program (LaHIPP) Website:<br/> <a href="https://www.ldh.la.gov/lahipp">https://www.ldh.la.gov/lahipp</a><br/>           LaHIPP phone: 1-877-697-6703<br/>           LaHIPP email: <a href="mailto:La.HIPP@la.gov">La.HIPP@la.gov</a><br/>           LaHIPP fax: 1-888-716-9787<br/>           LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p> |
| MAINE – Medicaid  | MASSACHUSETTS – Medicaid and CHIP  |
| <p>Enrollment Website:<br/> <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a><br/>           Phone: 1-800-442-6003<br/>           TTY: Maine relay 711<br/>           Private Health Insurance Premium Webpage:<br/> <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br/>           Phone: 1-800-977-6740<br/>           TTY: Maine relay 711</p>   | <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a><br/>           Phone: 1-800-862-4840<br/>           TTY: 711<br/>           Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>  |
| MINNESOTA – Medicaid  | MISSOURI – Medicaid  |
| <p>Website:<br/> <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a><br/>           Phone: 1-800-657-3672</p>   | <p>Website:<br/> <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br/>           Phone: 573-751-2005</p>  |
| MONTANA – Medicaid  | NEBRASKA – Medicaid  |
| <p>Website:<br/> <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br/>           Phone: 1-800-694-3084<br/>           Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>  | <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a><br/>           Phone: 1-855-632-7633<br/>           Lincoln: 402-473-7000<br/>           Omaha: 402-595-1178</p>   |

| NEVADA – Medicaid   | NEW HAMPSHIRE – Medicaid   |
|---|--|
| <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a><br/> Medicaid Phone: 1-800-992-0900</p>  | <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a><br/> Phone: 603-271-5218<br/> Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br/> Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>   |
| NEW JERSEY – Medicaid and CHIP  | NEW YORK – Medicaid  |
| <p>Medicaid Website:<br/> <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br/> Phone: 1-800-356-1561<br/> CHIP Premium Assistance Phone: 609-631-2392<br/> CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br/> CHIP Phone: 1-800-701-0710 (TTY: 711)</p>   | <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br/> Phone: 1-800-541-2831</p>   |
| NORTH CAROLINA – Medicaid   | NORTH DAKOTA – Medicaid  |
| <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a><br/> Phone: 919-855-4100</p>  | <p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a><br/> Phone: 1-844-854-4825</p>   |
| OKLAHOMA – Medicaid and CHIP  | OREGON – Medicaid and CHIP   |
| <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br/> Phone: 1-888-365-3742</p>  | <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br/> Phone: 1-800-699-9075</p>   |
| PENNSYLVANIA – Medicaid and CHIP  | RHODE ISLAND – Medicaid and CHIP   |
| <p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a><br/> Phone: 1-800-692-7462<br/> CHIP Website: <a href="http://www.dhs.pa.gov/childrens-health-insurance-program">Children's Health Insurance Program (CHIP) (pa.gov)</a><br/> CHIP Phone: 1-800-986-KIDS (5437)</p> | <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br/> Phone: 1-855-697-4347, or<br/> 401-462-0311 (Direct Rlte Share Line)</p>  |
| SOUTH CAROLINA – Medicaid   | SOUTH DAKOTA - Medicaid  |
| <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br/> Phone: 1-888-549-0820</p>  | <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br/> Phone: 1-888-828-0059</p>   |
| TEXAS – Medicaid  | UTAH – Medicaid and CHIP   |
| <p>Website: <a href="http://www.dhs.texas.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a><br/> Phone: 1-800-440-0493</p>  | <p>Utah's Premium Partnership for Health Insurance (UPP)<br/> Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a><br/> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a><br/> Phone: 1-888-222-2542<br/> Adult Expansion Website:<br/> <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a><br/> Utah Medicaid Buyout Program Website:<br/> <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a><br/> CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a></p> |
| VERMONT– Medicaid   | VIRGINIA – Medicaid and CHIP   |
| <p>Website: <a href="http://www.dhs.vermont.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a><br/> Phone: 1-800-250-8427</p>  | <p>Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a><br/> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a><br/> Medicaid/CHIP Phone: 1-800-432-5924</p>  |

| WASHINGTON – Medicaid  | WEST VIRGINIA – Medicaid and CHIP  |
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| Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a><br>Phone: 1-800-562-3022  | Website: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a><br><a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| WISCONSIN – Medicaid and CHIP  | WYOMING – Medicaid   |
| Website:<br><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a><br>Phone: 1-800-362-3002 | Website:<br><a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a><br>Phone: 1-800-251-1269                         |

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
 Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
 1-877-267-2323, Menu Option 4, Ext. 6156

## Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos. Para obtener más información, visite [www.cuidadodesalud.gov](http://www.cuidadodesalud.gov).

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al **1-877-KIDS NOW** o visite [espanol.insurekidsnow.gov/](http://espanol.insurekidsnow.gov/) para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de “inscripción especial”, y **usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas**. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de [www.askebsa.dol.gov](http://www.askebsa.dol.gov) o llame al servicio telefónico gratuito **1-866-444-EBSA (3272)**.

**Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2026. Comuníquese con su estado para obtener más información sobre la elegibilidad –**

| ALABAMA – Medicaid  | ALASKA – Medicaid   |
|---|---|
| Sitio web: <a href="http://myalhipp.com">http://myalhipp.com</a><br>Teléfono: 1-855-692-5447                  | El Programa de Pago de AK primas del seguro médico<br>Sitio web: <a href="http://myakhipp.com">http://myakhipp.com</a><br>Teléfono: 1-866-251-4861<br>Por correo electrónico:<br><a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a><br>Elegibilidad de Medicaid:<br><a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a> |
| ARKANSAS – Medicaid   | CALIFORNIA – Medicaid   |
| Sitio web: <a href="http://myarhipp.com/">http://myarhipp.com/</a><br>Teléfono: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Sitio web: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a><br>Teléfono: 916-445-8322<br>Fax: 916-440-5676<br>Por correo electrónico: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>  |

| <b>COLORADO – Health First Colorado<br/>(Programa Medicaid de Colorado) y Child<br/>Health Plan Plus (CHP+)</b>   | <b>FLORIDA – Medicaid</b>   |
|---|---|
| <p>Sitio web de Health First Colorado:<br/> <a href="https://www.healthfirstcolorado.com/es">https://www.healthfirstcolorado.com/es</a><br/>           Centro de atención al cliente de Health First Colorado:<br/>           1-800-221-3943/ retransmisor del estado: 711<br/>           CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a><br/>           Atención al cliente de CHP+: 1-800-359-<br/>           1991/retransmisor del estado: 711<br/>           Programa de compra de seguro de salud (HIBI, por sus<br/>           siglas en inglés): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a><br/>           Atención al cliente de HIBI: 1-855-692-6442</p>  | <p>Sitio web:<br/> <a href="https://www.flmedicaidplrecovery.com/flmedicaidplr&lt;br/&gt;           ecovery.com/hipp/index.html">https://www.flmedicaidplrecovery.com/flmedicaidplr<br/>           ecovery.com/hipp/index.html</a><br/>           Teléfono: 1-877-357-3268</p>  |
| <b>GEORGIA – Medicaid</b>   | <b>INDIANA – Medicaid</b>   |
| <p>Sitio web de GA HIPP:<br/> <a href="https://medicaid.georgia.gov/health-insurance-&lt;br/&gt;           premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-<br/>           premium-payment-program-hipp</a><br/>           Teléfono: 678-564-1162, Presiona 1<br/>           Sitio web de GA CHIPRA:<br/> <a href="https://medicaid.georgia.gov/programs/third-party-&lt;br/&gt;           liability/childrens-health-insurance-program-&lt;br/&gt;           reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-<br/>           liability/childrens-health-insurance-program-<br/>           reauthorization-act-2009-chipra</a><br/>           Teléfono: 678-564-1162, Presiona 2</p>   | <p>Programa de pago de primas de seguro de salud<br/>           Todos los demás son Medicaid<br/>           Sitio web: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a><br/> <a href="https://www.in.gov/fssa/dfr">https://www.in.gov/fssa/dfr</a><br/>           Administración de familias y servicios sociales<br/>           Teléfono: 1-800-403-0864<br/>           Teléfono de servicios para miembros: 1-800-457-4584</p> |
| <b>IOWA – Medicaid y CHIP (Hawki)</b>   | <b>KANSAS – Medicaid</b>  |
| <p>Sitio web de Medicaid:<br/> <a href="https://hhs.iowa.gov/programs/welcome-iowa-&lt;br/&gt;           medicaid">https://hhs.iowa.gov/programs/welcome-iowa-<br/>           medicaid</a><br/>           Teléfono de Medicaid: 1-800-338-8366<br/>           Sitio web de Hawki:<br/> <a href="https://hhs.iowa.gov/programs/welcome-iowa-&lt;br/&gt;           medicaid/iowa-health-link/hawki">https://hhs.iowa.gov/programs/welcome-iowa-<br/>           medicaid/iowa-health-link/hawki</a><br/>           Teléfono de Hawki: 1-800-257-8563<br/>           Sitio web de HIPP:<br/> <a href="https://hhs.iowa.gov/programs/welcome-iowa-&lt;br/&gt;           medicaid/fee-service/hipp">https://hhs.iowa.gov/programs/welcome-iowa-<br/>           medicaid/fee-service/hipp</a><br/>           Teléfono de HIPAA: 1-888-346-9562</p> | <p>Sitio web: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a><br/>           Teléfono: 1-800-792-4884<br/>           Teléfono de HIPP: 1-800-967-4660</p>   |

| KENTUCKY - Medicaid  | LOUISIANA – Medicaid   |
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| <p>Sitio web del Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):<br/> <a href="https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br/> Teléfono: 1-855-459-6328<br/> Por correo electrónico: KIHIPP.PROGRAM@ky.gov<br/> Sitio web de KCHIP:<br/> <a href="https://kidshealth.ky.gov/es/Pages/default.aspx">https://kidshealth.ky.gov/es/Pages/default.aspx</a><br/> Teléfono: 1-877-524-4718<br/> Sitio web de Medicaid de Kentucky:<br/> <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a><br/> Sitio web de Medicaid de Kentucky:<br/> <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p> | <p>Sitio web: <a href="https://www.ldh.la.gov/healthy-louisiana">https://www.ldh.la.gov/healthy-louisiana</a><br/> Teléfono: 1-888-342-6207 (línea directa de Medicaid) o 1-855-618-5488 (LaHIPP)<br/> Louisiana Medicaid email: <a href="mailto:healthy@la.gov">healthy@la.gov</a><br/> Louisiana Health Insurance Premium Program (LaHIPP) Website:<br/> <a href="https://www.ldh.la.gov/lahipp">https://www.ldh.la.gov/lahipp</a><br/> LaHIPP phone: 1-877-697-6703<br/> LaHIPP email: <a href="mailto:La.HIPP@la.gov">La.HIPP@la.gov</a><br/> LaHIPP fax: 1-888-716-9787<br/> LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p> |
| MAINE – Medicaid   | MASSACHUSETTS – Medicaid y CHIP  |
| <p>Sitio web por inscripción:<br/> <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a><br/> Teléfono: 1-800-442-6003<br/> TTY: Maine relay 711<br/> Página web por primos de seguro de salud privado:<br/> <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br/> Teléfono: 1-800-977-6740<br/> TTY: Maine relay 711</p>   | <p>Sitio web: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a><br/> Teléfono: 1-800-862-4840<br/> TTY: 711<br/> Por correo electrónico:<br/> <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>   |
| MINNESOTA – Medicaid   | MISSOURI – Medicaid  |
| <p>Sitio web: <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a><br/> Teléfono: 1-800-657-3672</p>  | <p>Sitio web:<br/> <a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">https://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br/> Teléfono: 573-751-2005</p>   |
| MONTANA – Medicaid   | NEBRASKA – Medicaid  |
| <p>Sitio web:<br/> <a href="https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br/> Teléfono: 1-800-694-3084<br/> Por correo electrónico: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>   | <p>Sitio web: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a><br/> Teléfono: 1-855-632-7633<br/> Lincoln: 402-473-7000<br/> Omaha: 402-595-1178</p>  |
| NEVADA – Medicaid  | NUEVO HAMPSHIRE – Medicaid   |
| <p>Sitio web de Medicaid: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a><br/> Teléfono de Medicaid: 1-800-992-0900</p>  | <p>Sitio web: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a><br/> Teléfono: 603-271-5218<br/> Teléfono gratuito para el programa de HIPP: 1-800-852-3345, ext. 15218<br/> Por correo electrónico:<br/> <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>   |

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| <p align="center"><b>NUEVA JERSEY – Medicaid y CHIP</b></p> <p>Sitio web de Medicaid:<br/> <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br/> Teléfono: 1-800-356-1561<br/> Teléfono de asistencia de prima de CHIP: 609-631-2392<br/> Sitio web de CHIP:<br/> <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br/> Teléfono de CHIP: 1-800-701-0710 (TTY:711)</p> | <p align="center"><b>NUEVA YORK – Medicaid</b></p> <p>Sitio web:<br/> <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br/> Teléfono: 1-800-541-2831</p>   |
| <p align="center"><b>CAROLINA DEL NORTE – Medicaid</b></p>   | <p align="center"><b>DAKOTA DEL NORTE – Medicaid</b></p>  |
| <p>Sitio web: <a href="https://medicaid.ncdhhs.gov">https://medicaid.ncdhhs.gov</a><br/> Teléfono: 919-855-4100</p>  | <p>Sitio web: <a href="http://www.hhs.nd.gov/healthcare">http://www.hhs.nd.gov/healthcare</a><br/> Teléfono: 1-844-854-4825</p>   |
| <p align="center"><b>OKLAHOMA – Medicaid y CHIP</b></p>  | <p align="center"><b>OREGON – Medicaid y CHIP</b></p>   |
| <p>Sitio web: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br/> Teléfono – 1-888-365-3742</p>   | <p>Sitio web:<br/> <a href="https://cuidadodesalud.oregon.gov/Pages/index.aspx">https://cuidadodesalud.oregon.gov/Pages/index.aspx</a><br/> Teléfono: 1-800-699-9075</p>  |
| <p align="center"><b>PENSILVANIA – Medicaid y CHIP</b></p>   | <p align="center"><b>RHODE ISLAND– Medicaid y CHIP</b></p>  |
| <p>Sitio web: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a><br/> Teléfono: 1-800-692-7462<br/> Sitio web de CHIP:<br/> <a href="https://www.pa.gov/en/agencies/dhs/resources/chip.html">https://www.pa.gov/en/agencies/dhs/resources/chip.html</a><br/> Teléfono de CHIP: 1-800-986-JIDS (5437)</p>                    | <p>Sitio web: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br/> Teléfono: 1-855-697-4347 o 401-462-0311 (Direct Rita Share Line)</p>   |
| <p align="center"><b>CAROLINA DEL SUR – Medicaid</b></p>   | <p align="center"><b>DAKOTA DEL SUR – Medicaid y CHIP</b></p>   |
| <p>Sitio web: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br/> Teléfono: 1-888-549-0820</p>  | <p>Sitio web: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br/> Teléfono: 1-888-828-0059</p>   |
| <p align="center"><b>TEXAS – Medicaid</b></p>  | <p align="center"><b>UTAH– Medicaid y CHIP</b></p>  |
| <p>Sitio web:<br/> <a href="https://www.hhs.texas.gov/es/servicios/finanzas/progr-ama-de-pago-de-las-primas-del-seguro-medico">https://www.hhs.texas.gov/es/servicios/finanzas/progr-ama-de-pago-de-las-primas-del-seguro-medico</a><br/> Teléfono: 1-800-440-0493</p>   | <p>Utah’s Premium Partnership for Health Insurance (UPP)<br/> Sitio web: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a><br/> Por correo electrónico: <a href="mailto:upp@utah.gov">upp@utah.gov</a><br/> Teléfono: 1-888-222-2542<br/> Sitio web de expansión para adultos:<br/> <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a><br/> Sitio web de Programa de compra de Medicaid de Utah: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a><br/> Sitio web de CHIP: <a href="https://chip.utah.gov/espanol/">https://chip.utah.gov/espanol/</a></p> |

| VERMONT – Medicaid  | VIRGINIA – Medicaid y CHIP  |
|---|---|
| Sitio web:<br><a href="https://www.vermont.gov/health/hipp">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a><br>Teléfono: 1-800-250-8427 | Sitio web:<br><a href="https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/famis-select">https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/famis-select</a><br><a href="https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a><br>Teléfono de Medicaid/CHIP: 1-800-432-5924 |
| WASHINGTON – Medicaid   | WEST VIRGINIA – Medicaid y CHIP   |
| Sitio web: <a href="http://www.hca.wa.gov">http://www.hca.wa.gov</a><br>Teléfono: 1-800-562-3022  | Sitio web: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a><br><a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Teléfono de Medicaid: 304-558-1700<br>Teléfono gratuito de CHIP: 1-855-MyWVHIPP (1-855-699-8447)   |
| WISCONSIN – Medicaid y CHIP   | WYOMING – Medicaid  |
| Sitio web:<br><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a><br>Teléfono: 1-800-362-3002         | Sitio web:<br><a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a><br>Teléfono: 1-800-251-1269   |

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2026, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.  
 Administración de Seguridad de Beneficios de los Empleados  
[www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol](http://www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol)  
 1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.  
 Centros para Servicios de Medicare y Medicaid  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
 1-877-267-2323, opción de menú 4, Ext. 6156

# General Notice of COBRA Rights

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## Continuation Coverage Rights Under COBRA

### 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Roanoke County Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### 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;
- 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:**

**Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019**

### 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, 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](http://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 period<sup>1</sup> 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

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<sup>1</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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](http://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](http://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

2026-2027 Plan Year  
Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019

# Modelo de aviso general de los derechos de la cobertura de continuación de COBRA

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*(para que usen los planes de salud grupales de un solo empleador)*

## **\*\*Derechos de la cobertura de continuación conforme a la ley COBRA\*\***

### Introducción

Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

**Al perder la cobertura de salud grupal, puede haber otras opciones disponibles.** Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

### ¿Qué es la cobertura de continuación de COBRA?

La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como “evento específico”. Los eventos específicos se incluyen más abajo en este aviso. Después de un evento específico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un “beneficiario que cumple con los requisitos”. Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento específico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de COBRA debe pagar la cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:

- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:

- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos específicos:

- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como “hijo dependiente”.

A veces, presentar una solicitud de declaración de quiebra conforme al Título 11 del Código de Estados Unidos puede ser un evento habilitante. Si se presenta una solicitud de declaración de quiebra con respecto a Roanoke County Public Schools y esa quiebra causa la pérdida de la cobertura de cualquier empleado jubilado cubierto por el Plan, el empleado jubilado se convertirá en un beneficiario que cumple con los requisitos. El cónyuge del empleado jubilado, el cónyuge sobreviviente y los hijos dependientes también se convertirán en beneficiarios que cumplen con los requisitos si la quiebra causa la pérdida de la cobertura del Plan.

### ¿Cuándo está disponible la cobertura de continuación de COBRA?

El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento específico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:

- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).

**Para todos los otros eventos específicos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a:**

**Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019**

## ¿Cómo se proporciona la cobertura de continuación de COBRA?

Después de que el administrador del Plan recibe el aviso de que se ha producido un evento específico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.

La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos específicos, o un segundo evento específico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

### Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA

Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una extensión adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA.

### Extensión por un segundo evento específico del período de 18 meses de la cobertura de continuación de COBRA

Si su familia sufre otro evento específico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento específico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o ex empleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento específico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento específico.

## ¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un “período de inscripción especial”. Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en [www.cuidadodesalud.gov](http://www.cuidadodesalud.gov).

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del período de inscripción inicial, hay un período de inscripción especial de 8 meses<sup>[1]</sup> para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.
- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes “disminuyan” el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite [www.medicare.gov/medicare-and-you](http://www.medicare.gov/medicare-and-you)

### Si tiene preguntas

Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite [www.cuidadodesalud.gov](http://www.cuidadodesalud.gov).

### Informe a su plan si cambia de dirección

Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

### Información de contacto del Plan

2026-2027 Plan Year

Tracy Bandy

5937 Cove Road

Roanoke, VA 24019

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<sup>[1]</sup>[www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-period](http://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-period).

# EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

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## The United States Department of Labor Wage and Hour Division

### Leave Entitlements

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 1 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.

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For additional information or to file a complaint:

**1-866-4-USWAGE**

(1-866-487-9243) TTY: 1-877-889-5627

[www.dol.gov/whd](http://www.dol.gov/whd)

U.S. Department of Labor | Wage and Hour Division

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# Genetic Information Nondiscrimination Act (GINA) Disclosures

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## Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

# Health Insurance Exchange Notice

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*For Employers Who Offer a Health Plan to Some or All Employees*

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

### **PART A: General Information**

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

#### ***What is the Health Insurance Marketplace?***

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>1</sup> of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.<sup>12</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if

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

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

the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

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

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

### ***What about Alternatives to Marketplace Health Insurance Coverage?***

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

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

## How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019

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

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

|   |   |                      |
|---|---|----------------------|
| 3. Employer name<br>Roanoke County Public Schools                                 | 4. Employer Identification Number (EIN)<br>54-1591193 |                      |
| 5. Employer address<br>5937 Cove Road   | 6. Employer phone number<br>(540) 562-3900            |                      |
| 7. City<br>Roanoke  | 8. State<br>VA  | 9. ZIP code<br>24019 |
| 10. Who can we contact about employee health coverage at this job?<br>Tracy Bandy |   |                      |
| 11. Phone number<br>(540) 540-3900  | 12. Email address<br>tjbandy@rcps.us                  |                      |

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

- As your employer, we offer a health plan to:
  - Some employees. Eligible employees are: Full-time employees regularly working 30+ hours per week and retirees
  - With respect to dependents:
    - We do offer coverage. Eligible dependents are: spouses and dependent child under age 26
    - If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

# Aviso de Intercambio de Seguros de Salud

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*Para los empleadores que ofrecen un plan de salud a algunos o a todos los empleados*

## Cobertura del Mercado de Seguros Médicos Opciones y su cobertura de salud

### **PARTE A: Información general**

Incluso si le ofrecen cobertura de salud a través de su empleo, es posible que tenga otras opciones de cobertura a través del Mercado de Seguros Médicos (“Mercado”). Para ayudarlo a evaluar las opciones para usted y su familia, este aviso proporciona cierta información básica sobre el Mercado de Seguros Médicos y la cobertura de salud ofrecida a través de su empleo.

### **¿Qué es el Mercado de Seguros Médicos?**

El Mercado está diseñado para ayudarlo a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El Mercado ofrece un “punto único de compra” para encontrar y comparar opciones de seguros médicos privados en su área geográfica.

### **¿Puedo ahorrar dinero en las primas de mi seguro médico en el Mercado?**

Es posible que califique para ahorrar dinero y reducir su prima mensual y otros costos de bolsillo, pero solo si su empleador no ofrece cobertura o si ofrece cobertura que no se considera asequible para usted y no cumple con ciertas normas de valor mínimo (que se analizan a continuación). Los ahorros para los que es elegible dependen de los ingresos de su hogar. También puede ser elegible para un crédito fiscal que reduzca sus costos.

### **¿La cobertura de salud basada en el empleo afecta la elegibilidad para recibir ahorros en primas a través del Mercado?**

Sí. Si tiene una oferta de cobertura de salud de su empleador que se considera asequible para usted y cumple con ciertas normas de valor mínimo, no será elegible para un crédito fiscal o pago por adelantado del crédito fiscal para su cobertura del Mercado y es posible que desee inscribirse en su plan de salud basado en el empleo. Sin embargo, usted puede ser elegible para un crédito fiscal y pagos por adelantado del crédito, que reducen su prima mensual, o una reducción en ciertos costos compartidos, si su empleador no le ofrece cobertura alguna o no le ofrece cobertura que se considera asequible para usted o cumple con las normas de valor mínimo. Si su participación del costo de la prima de todos los planes que se le ofrecen a través de su empleo es más del 9.12 %<sup>1</sup> de su ingreso familiar anual, o si la cobertura a través de su empleo no cumple con la norma de “valor mínimo” establecida por la Ley de Cuidado de la Salud a Bajo Precio, puede ser elegible para un crédito fiscal y el pago por adelantado del crédito, si no se inscribe en la cobertura de salud basada en el empleo. Para los miembros de la familia del empleado, la cobertura se considera asequible si el costo de las primas del plan de menor costo que cubriría a todos los miembros de la familia no excede el 9.12 % de los ingresos del hogar del empleado.<sup>12</sup>

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<sup>1</sup> Indexado anualmente; consulte <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> para 2023.

<sup>2</sup> Un plan de salud patrocinado por el empleador o basado en el empleo cumple con la “norma de valor mínimo” si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos. A los efectos de la elegibilidad para el crédito fiscal para la prima, para cumplir con la “norma de valor mínimo”, el plan de salud también debe proporcionar una cobertura sustancial tanto de los servicios hospitalarios como de los servicios médicos para pacientes hospitalizados.

Nota: si compra un plan de salud a través del Mercado, en lugar de aceptar la cobertura de salud ofrecida a través de su empleo, entonces puede perder el acceso a todo lo que el empleador contribuya a la cobertura basada en el empleo. Además, esta contribución del empleador, así como la contribución de su empleado a la cobertura basada en el empleo, generalmente se excluye de los ingresos para efectos del impuesto sobre la renta federal y estatal. Sus pagos de cobertura a través del Mercado se realizan después de impuestos. Además, tenga en cuenta que, si la cobertura de salud ofrecida a través de su empleo no cumple con las normas de asequibilidad o valor mínimo, pero acepta esa cobertura de todos modos, no será elegible para un crédito fiscal. Debe considerar todos estos factores al determinar si debe comprar un plan de salud a través del Mercado.

### ***¿Cuándo puedo inscribirme en una cobertura de seguro médico a través del Mercado?***

Puede inscribirse en un plan de seguro médico del Mercado durante el Período de Inscripción Abierta anual del Mercado. La Inscripción Abierta varía según el estado, pero generalmente comienza el 1 de noviembre y continúa al menos hasta el 15 de diciembre.

Fuera del Período de Inscripción Abierta anual, puede inscribirse en un seguro médico si califica para un Período de Inscripción Especial. En general, usted califica para un Período de Inscripción Especial si ha tenido ciertos eventos de vida calificativos, como casarse, tener un bebé, adoptar un niño o perder la elegibilidad para otra cobertura de salud. Dependiendo de su tipo de Período de Inscripción Especial, es posible que tenga 60 días antes o 60 días después del evento de vida calificativo para inscribirse en un plan del Mercado.

También existe un Período de Inscripción Especial del Mercado para personas y sus familias que pierden la elegibilidad para la cobertura de Medicaid o del Programa de Seguro Médico para Niños (CHIP, por sus siglas en inglés) a partir del 31 de marzo de 2023 hasta el 31 de julio de 2024. Desde el inicio de la emergencia de salud pública del COVID-19 a nivel nacional, las agencias estatales de Medicaid y CHIP generalmente no han cancelado la inscripción de ningún beneficiario de Medicaid o CHIP que estuviera inscrito a partir del 18 de marzo de 2020 hasta el 31 de marzo de 2023. A medida que las agencias estatales de Medicaid y CHIP reanuden las prácticas habituales de elegibilidad e inscripción, es posible que muchas personas ya no sean elegibles para la cobertura de Medicaid o CHIP a partir del 31 de marzo de 2023. El Departamento de Salud y Servicios Humanos de EE. UU. **ofrece un período temporal de Inscripción Especial en el Mercado para permitir que estas personas se inscriban en la cobertura del Mercado.**

Las personas elegibles para el Mercado que viven en estados atendidos por HealthCare.gov y que envían una nueva solicitud o actualizan una solicitud existente en HealthCare.gov entre el 31 de marzo de 2023 y el 31 de julio de 2024, y dan fe de una fecha de terminación de la cobertura de Medicaid o CHIP dentro del mismo período, son elegibles para un Período de Inscripción Especial de 60 días. **Eso significa que, si pierde la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 31 de julio de 2024, es posible que pueda inscribirse en la cobertura del Mercado dentro de los 60 días posteriores a la pérdida de la cobertura de Medicaid o CHIP.** Además, si usted o los miembros de su familia están inscritos en la cobertura de Medicaid o CHIP, es importante asegurarse de que su información de contacto esté actualizada para asegurarse de recibir cualquier información sobre los cambios en su elegibilidad. Para obtener más información, visite HealthCare.gov o llame al Centro de Llamadas del Mercado al 1-800-318-2596. Los usuarios de TTY pueden llamar al 1-855-889-4325.

### ***¿Qué pasa con las alternativas a la cobertura de seguro médico del Mercado?***

Si usted o su familia son elegibles para la cobertura de un plan de salud basado en el empleo (como un plan de salud patrocinado por el empleador), usted o su familia también pueden ser elegibles para un Período de Inscripción Especial para inscribirse en ese plan de salud en ciertas circunstancias, incluso si usted o las

personas a su cargo estaban inscritos en la cobertura de Medicaid o CHIP y perdieron esa cobertura. Generalmente, tiene 60 días después de la pérdida de la cobertura de Medicaid o CHIP para inscribirse en un plan de salud basado en el empleo, pero si usted y su familia perdieron la elegibilidad para la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 10 de julio de 2023, puede solicitar esta inscripción especial en el plan de salud basado en el empleo hasta el 8 de septiembre de 2023. Confirme la fecha límite con su empleador o con su plan de salud basado en el empleo.

Alternativamente, puede inscribirse en la cobertura de Medicaid o CHIP en cualquier momento completando una solicitud a través del Mercado o solicitando directamente a través de su agencia estatal de Medicaid. Visite <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> para obtener más detalles.

**¿Cómo puedo obtener más información?**

Para obtener más información sobre la cobertura que ofrece a través de su empleo, consulte el Resumen de la descripción del plan de salud o comuníquese con

Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019

El Mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para cobertura a través del Mercado y su costo. Visite [HealthCare.gov](http://HealthCare.gov) para obtener más información, incluida una solicitud en línea para cobertura de seguro médico e información de contacto de un Mercado de Seguros Médicos en su área.

**PARTE B: Información sobre la cobertura de salud ofrecida por su empleador**

Esta sección contiene información sobre cualquier cobertura de salud ofrecida por su empleador. Si decide completar una solicitud de cobertura en el Mercado, se le pedirá que proporcione esta información. Esta información está numerada según la solicitud del Mercado.

|   |  |                           |
|---|--|---------------------------|
| 3. Nombre del empleador<br>Roanoke County Public Schools  | 4. Número de identificación patronal (EIN)<br>54-1591193 |                           |
| 5. Dirección del empleador<br>5937 Cove Road  | 6. Número de teléfono del empleador<br>(540) 562-3900    |                           |
| 7. Ciudad<br>Roanoke  | 8. Estado<br>VA  | 9. Código postal<br>24019 |
| 10. ¿A quién podemos contactar sobre la cobertura de salud de los empleados en este trabajo?<br>Tracy Bandy |  |                           |
| 11. Número de teléfono (si es diferente al anterior)<br>(540) 540-3900                                      | 12. Dirección de correo electrónico<br>tjbandy@rcps.us   |                           |

A continuación, se ofrece información básica sobre la cobertura de salud que ofrece este empleador:

- Como su empleador, ofrecemos un plan de salud para:
  - Some employees. Eligible employees are: Full-time employees regularly working 30+ hours per week and retirees
  - Respecto a los dependientes:
  - We do offer coverage. Eligible dependents are: spouses and dependent child under age 26

Si se marca, esta cobertura cumple con la norma de valor mínimo y el costo de esta cobertura para usted debe ser asequible, según los salarios de los empleados.

Nota: Incluso si su empleador tiene la intención de que su cobertura sea asequible, aún puede ser elegible para un descuento en la prima a través del Mercado. El Mercado utilizará los ingresos de su hogar, junto con otros factores, para determinar si puede ser elegible para un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a otra (quizás es un empleado por horas o trabaja por comisión), si es nuevo empleado a mitad de año o si tiene otras pérdidas de ingresos, aún puede calificar para un descuento en la prima.

## Medicare Part D Creditable Coverage Notice

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### Important Notice from Roanoke County Public Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Roanoke County Public Schools 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. Roanoke County Public Schools has determined that the prescription drug coverage offered by the Roanoke County Public Schools Plan 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 15<sup>th</sup> to December 7<sup>th</sup>.

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

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

If you decide to join a Medicare drug plan, your current Roanoke County Public Schools coverage will be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Roanoke County Public Schools coverage, be aware that you and your dependents will be able to get this coverage back.

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Roanoke County Public Schools 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 call Tracy Bandy at (540) 540-3900. 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 Roanoke County Public Schools changes. You also may request a copy of this notice at any time.

## 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](http://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](http://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).**

Date: 4/15/2026

Name of Entity/Sender: Roanoke County Public Schools

Contact--Position/Office: Tracy Bandy, HR Benefits Manager

Address: 5937 Cove Road Roanoke, VA 24019

Phone Number: (540) 540-3900

## Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

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The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (540) 540-3900.

## Newborns' and Mothers' Health Protection Act Notice

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).

## Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

### What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

### You're protected from balance billing for:

#### **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

<https://www.scc.virginia.gov/consumers/insurance/health-insurance-consumer/balance-billing-protection/>

#### **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

<https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3445.01/>  
<https://www.cms.gov/nosurprises>

**When balance billing isn't allowed, you also have these protections:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you think you've been wrongly billed**, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit [www.cms.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

## Notice of Patient Protections

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The Roanoke County Public Schools Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Roanoke County Public Schools designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Tracy Bandy

5937 Cove Road

Roanoke, VA 24019

For children, you may designate a pediatrician as the primary care provider.

# Notice of Privacy Practices

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Roanoke County Public Schools  
5937 Cove Road  
Roanoke, VA 24019

## Privacy Official:

Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019

Effective Date: 07/01/2026

## Your Information. Your Rights. Our Responsibilities.

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.**

## Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

## Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us at:  
Tracy Bandy  
5937 Cove Road  
Roanoke, VA 24019
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

#### **Run our organization**

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

### **Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

### **Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

### **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

### **Other Information**

## Notice of Special Enrollment Rights

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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 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).

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 or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Tracy Bandy

5937 Cove Road

Roanoke, VA 24019

# USERRA Notice

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## *Your Rights Under USERRA*

### A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

### B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

### C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

## D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

## E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at <https://www.dol.gov/agencies/vets>. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: <https://www.dol.gov/sites/dolgov/files/VETS/files/USERRA-Poster.pdf>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

# Women's Health and Cancer Rights Act (WHCRA) Notices

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## 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, the following deductibles and coinsurance apply: \$see Summary of Benefits deductible (in-network) and see Summary of Benefits% coinsurance (in-network) and \$see Summary of Benefits deductible (out-of-network) and see Summary of Benefits% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (540) 540-3900.

## 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 (540) 540-3900 for more information.