Zachary Community School District

2026-2027

EMPLOYEE BENEFITS GUIDE

Plan Year: September 1, 2026 to August 31, 2027

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact Gallagher. ZCSD has partnered with Gallagher as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

IMPORTANT CONTACT INFORMATION

Carrier	Group #	Web / Email	Phone
Medical and Prescription			
Blue Cross Blue Shield of Louisiana	77216FF1	www.lablue.com	1-800-599-2583
Pharmacy Rx BIN:	003858 PCN-A4 (BSLA)		
Health Savings Account			
iSolved Benefit Services		www.isolvedbenefitservices.com	1-800-300-3838
Dental			
Sun Life **New Carrier**	828542	www.sunlife.com	1-800-786-5433
Vision			
Sun Life **New Carrier**	828542	www.sunlife.com	1-800-786-5433
Basic & Voluntary Life and AD&D Insurance			
The Hartford **New Carrier**		www.thehartford.com	1-888-563-1124
Short-Term & Long-Term Disability			
The Hartford **New Carrier**		www.thehartford.com	1-888-277-4767
Employee Assistance Program (EAP)		www.guidanceresources.com	
Ability Assist® (The Hartford) **New Benefit**		Co Code: HLF902 Co Name: ABILI	1-800-964-3577
Bereavement, Funeral Planning & Family Support		empathy.com/partner/hartford	
The Hartford **New Benefit**		hartford@empathy.com	1-270-681-1364
Travel Insurance		thehartford.com/employee-benefits	1-800-243-6108 (U.S. & Can.)
The Hartford **New Benefit**		assist@imglobal.com	1-202-828-588 (Outside U.S.)
Voluntary Critical Illness Insurance			
Unum		www.unum.com	1-800-370-5856
Zachary Community School District			
Yolanda C. Williams, Director of Human Resources		yolanda.williams@zacharyschools.org	1-225-658-4969
Gallagher Benefits Helpline		www.EmployeeNavigator.com	
Monday-Friday, 8 am - 5:30 pm ET		ZacharySchools@AJG.com	1-225-336-3274

New Educational Video Library!

Check out our new educational video library designed to help you navigate the world of insurance with ease. This library features a collection of short, informative videos covering a wide range of insurance-related topics. Dive in and empower yourself with the knowledge to make informed decisions about your benefits!

Find links to individual videos throughout this guide, or check out the full library by clicking this box.

WELCOME TO YOUR EMPLOYEE BENEFITS!

The Zachary Community School District (ZCSD) is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by ZCSD in our employees. We are proud of our compensation benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the Employee Benefits Helpline.

Employee Benefits Helpline

1-225-336-3274

ZacharySchools@AJG.com

Sincerely,

Yolanda C. Williams

Director of Human Resources

WHAT'S INSIDE

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). ZCSD reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

HOW TO ENROLL

Open Enrollment Period

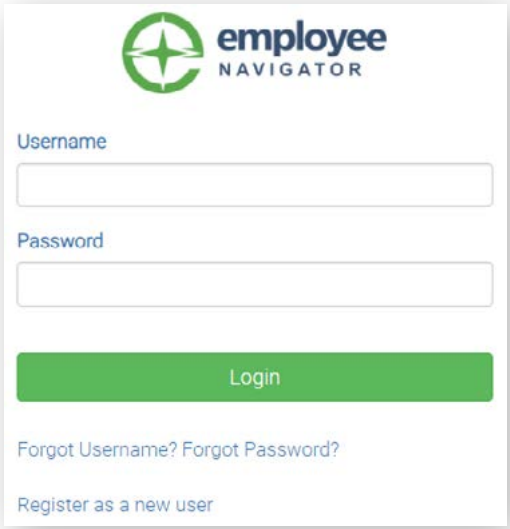
ZCSD's annual enrollment period will be held in August.

Log on to the enrollment site to review the benefits being offered, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance. Coverage, if elected, will begin on the first day of the month following 30 days of employment, provided you enroll online within **30 days of your date of hire.**

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.



Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online to review your current benefits and make any changes for the upcoming plan year.

www.EmployeeNavigator.com

The enrollment process will be broken down into 3 steps:

1. Log On: Visit our website: www.EmployeeNavigator.com

2. Register: Select New User Registration

3. Verify: Enter the following:

- First name
- Last name
- **Your Company Identifier: ZACHARY**
- Last 4 digits of SSN
- Date of birth (ex. 1/1/1970)

Browser Sites / Requirements:

We encourage you to keep your browser updated with the latest version.

- Google Chrome
- Mozilla Firefox
- Microsoft Edge
- Safari

~ You must have Cookies, Java-script, and Style Sheets enabled.

~ The system will automatically log you out if left idle for more than 30 minutes.

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ELIGIBILITY

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month following 30 days of employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in ZCSD's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

For all benefits you must enroll within 30 days from your date of hire by going to **www.EmployeeNavigator.com.**

Pre-Tax Benefits: Section 125

ZCSD's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, and vision coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

You must notify the Benefit Helpline at 1-225-336-3274 within 30 days from the life event status change in order to make a change in your benefit selections.

BENEFIT CHANGES

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, at its discretion, under applicable law and the plan provisions.

BENEFIT CHANGES CONTINUED...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact Gallagher to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Log onto **www.EmployeeNavigator.com** to add or drop dependents from your coverage if you experience a life event status change. Your user-name and password will be the same as you used during open enrollment. Click on "Life Events" and a series of easy-to-follow instructions will lead you through the enrollment process.

Watch a brief video on changing your elections following life events.

Update Your Elections Within 30 Days

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to Gallagher. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can call the Benefits Helpline at 1-225-336-3274 or e-mail **ZacharySchools@AJG.com.**

Build a Strong Relationship with Your Primary Care Physician

1. **Personalized Care:** A good relationship allows your PCP to understand your medical history, lifestyle, and preferences, leading to more tailored and effective healthcare.
2. **Trust and Communication:** Trust fosters open communication, making it easier to discuss sensitive issues and follow medical advice.
3. **Preventive Health:** Regular visits and a strong rapport can help in early detection and prevention of health issues.
4. **Coordination of Care:** Your PCP can coordinate with specialists and manage your overall healthcare plan, ensuring continuity and comprehensive care.
5. **Mental Health Support:** A trusted PCP can provide support for mental health concerns, offering guidance and referrals when needed.

Watch a brief video on how High Deductible Health Plans work.

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MEDICAL COVERAGE

ZCSD is proud to offer you a choice between three different medical plans. Coverage under all plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Option 1: Blue POS

The Blue POS Plan is a Point of Service Plan, or a POS for short. With this plan, an entire network of providers agrees to offer you its services.

- ✓ **Louisiana Only Network**
- ✓ Copays for most services, no deductible to fulfill

Option 2: Premier Blue

The Premier Blue Plan is a Preferred Provider Organization, or PPO for short. This plan offers you the freedom to receive care from any provider—in or out of your network. This means you can see any doctor or specialist, or use any hospital.

- ✓ **National Network**
- ✓ Some services require fulfilling the deductible first

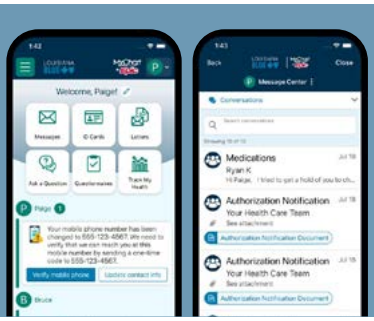
Option 3: Blue Saver HDHP

The Blue Saver HDHP is a High Deductible Health Plan, or HDHP for short. This plan functions like a Preferred Provider Organization (PPO), but features a lower monthly premium in exchange for a higher deductible.

- ✓ Higher deductible to fulfill before plan pays coinsurance
- ✓ Eligible to use Health Savings Account (more info on page 13)

ZCSD Contribution to your HSA

If you enroll in the Blue Saver HDHP, ZCSD will contribute **$1,500** for employee only, **$2,250** for +child(ren) or +spouse coverage, or **$3,000** for family coverage. More information on page 13.



We encourage you to download the MyLABlue Mobile App for locating providers, monitoring claims, and viewing your LA Blue ID Card. The app is free and available for iOS and Android.

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MEDICAL PLAN COMPARISON

	Option 1: **Blue POS** In-Network, You Pay:	*Option 2:* **Premier Blue** In-Network, You Pay:	*Option 3:* **Blue Saver HDHP** In-Network, You Pay:
Deductible (Individual / Family)	**$0 / $0**	**$500 / $1,500**	**$3,000 / $6,000**
ZCSD Contribution to your HSA (More information on page 13)	n/a	n/a	Employee Only: **$1,500** +Child(ren) or +Spouse: **$2,250** Family: **$3,000**
Out-Of-Pocket Maximum (Individual / Family)	$2,250 / $4,500	$3,250 / $6,500	$5,000 / $10,000*
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge	No charge
Office Visits Primary Care Visit Specialist Visit Telemedicine	 $25 copay $40 copay $25 copay	 $25 copay $40 copay $25 copay	 Deductible, then no charge Deductible, then no charge Varies
Diagnostic Tests	No charge	Deductible, then 10%	Deductible, then no charge
Imaging (MRI/CT)	No charge	Deductible, then 10%	Deductible, then no charge
Outpatient Surgery Facility	$350 copay	Deductible, then 10%	Deductible, then no charge
Emergency Room	$350 copay	$350 copay	Deductible, then no charge
Urgent Care	$40 copay	$40 copay	Deductible, then no charge
Inpatient Hospital Facility	$350/day (max 3)	Deductible, then 10%	Deductible, then no charge
Maternity Office Visits	$40 copay	No charge	Deductible, then no charge
Durable Medical Equipment	20% coinsurance	Deductible, then 20%	Deductible, then no charge
Prescription Drugs Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs Specialty Drugs	 $15 copay $40 copay $70 copay 10% up to $150	 $15 copay $40 copay $70 copay 10% up to $150	 Deductible, then no charge Deductible, then 20% Deductible, then 20% Deductible, then 20%
	Out-of-Network, You Pay:	**Out-of-Network, You Pay:**	**Out-of-Network, You Pay:**
Deductible (Individual / Family)	$1,000 / $3,000	$1,000 / $3,000	$6,000 / $12,000
Out-of-Pocket Max (Ind / Family)	$4,500 / $9,000	$6,500 / $13,000	$10,000 / $20,000
Coinsurance for Most Services	Deductible, then 30%	Deductible, then 30%	Deductible, then 20%

**$7,900 per person. This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.*

Plan Cost	**Blue POS** Full Monthly Premium	**Blue POS** Your Cost Per Pay (x24)	**Premier Blue** Full Monthly Premium	**Premier Blue** Your Cost Per Pay (x24)	**Blue Saver HDHP** Full Monthly Premium	**Blue Saver HDHP** Your Cost Per Pay (x24)
Employee Only	$1,088.08	$174.10	$1,027.37	$164.38	$775.61	$124.10
Employee + Spouse	$2,176.27	$348.20	$2,054.74	$328.76	$1,551.28	$248.20
Employee + Child(ren)	$2,012.82	$322.06	$1,900.39	$304.07	$1,434.78	$229.57
Family	$3,100.90	$496.14	$2,927.76	$468.45	$2,210.38	$353.71

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HOW OUR MEDICAL PLANS WORK

Let's get started!

Get Your Preventive Care

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ALL THREE PLANS PAY 100%

Here are some key things that you get at no charge:

- Adult physicals
- Mammograms
- Well-child exams and immunizations
- Prostate and colorectal screenings
- Routine prenatal maternity services
- Pap tests

Age and gender appropriate visit / screenings

Option 1 or 2: Blue POS or Premier Blue

Need a Prescription?

You pay the following copays for a 30-day supply:

Generic: $15

Preferred brand: $40

Specialty Drugs: 10% up to $150

Need Additional Care?

You pay the following copays for in-network services:

Office Visit: $25
Specialist Visit: $40
Urgent Care: $40
Physical Therapy: $40
Emergency Room: $350

For Most Other Care: Meet Your Deductible

$

YOU PAY 100%
Until you meet your DEDUCTIBLE

Option 3: Blue Saver HDHP

Need Additional Care or Prescription Drugs?

Meet Your Deductible

Your DEDUCTIBLE is the amount of money you must pay for covered services each year before the plan will start paying for all or part of the services.

$

YOU PAY 100%
Until you meet your DEDUCTIBLE

Pay Your Share

After you meet your deductible for either plan, you'll pay a COPAY or COINSURANCE for most covered services.

20% $ 80%

YOU PAY 20%
PLAN PAYS 80%

Reach the Out-of-Pocket Max

After you reach the OUT-OF-POCKET MAX, the plan will pay 100% of covered expenses for the remainder of the year.

$

PLAN PAYS 100%

Plan year ends

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WHERE SHOULD I GET CARE?

If you need emergency care, call 911, or seek help from any doctor or hospital immediately.

When should you go to the emergency room? You should go to the emergency room for life-threatening conditions, severe injuries, sudden severe symptoms, or serious health issues. For less severe issues, consider visiting an urgent care clinic or contacting your primary care physician. It's always better to err on the side of caution when it comes to your health.

Watch a brief video comparing primary care, urgent care, and the ER.

Telemedicine

- Available 24:7, 365 days a year.
- Secure video chat with certified doctor.
- Access on computer or mobile device.

Doctor's Office

- Office hours vary.
- Generally best place for non-emergencies.
- Doctor to patient relationship established; able to treat based on medical history.

Urgent Care Center

- Generally includes evenings, weekends, and holidays.
- Used when doctor's office closed, and not an emergency.
- Convenient access to medical care.

Hospital Emergency Room (ER)

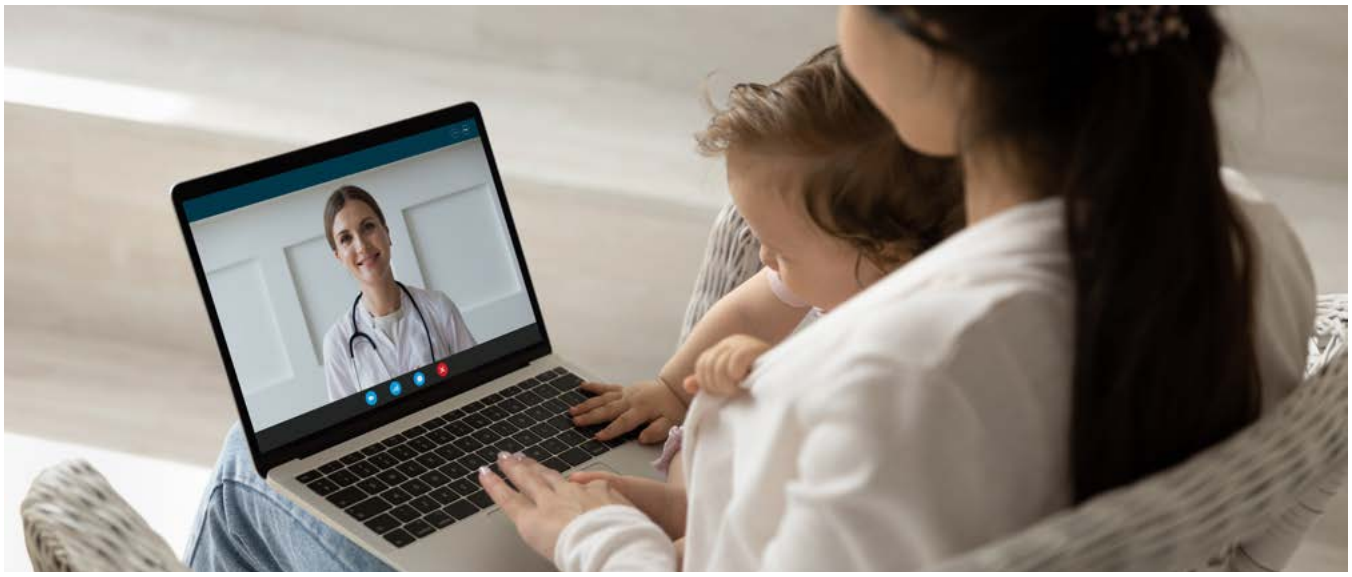
- Available 24:7, 365 days a year.
- Best option for a medical emergency.
- Highest cost to you.
- Potentially longer wait times.

What you'll pay in-network is based on your medical plan election:

	Telemedicine	Doctor's Office	Urgent Care Center	Emergency Room (ER)
Blue POS	**$25 copay**	$25 for PCP; $40 for specialist	$40 copay	$350 copay
Premier Blue	**$25 copay**	$25 for PCP; $40 for specialist	$40 copay	$350 copay
Blue Saver HDHP	**Varies by Provider Type**	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Average member cost based on claim data:		**$128**	**$110**	**$1,374**

Have a plan ready before you need it!

Download the MyLABlue Mobile App today or visit www.lablue.com/telehealth. If you don't have a Primary Care Physician, visit www.lablue.com.



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TELEMEDICINE / MYLABLUE

When it comes to healthcare, access is important. You want care that is convenient, high-quality, and low-cost. But depending on your condition, going to your personal physician or an urgent care clinic might not be your best option. We are proud to offer telemedicine/virtual visits.

How to register

Step 1: Visit www.lablue.com/telehealth or download the MyLABlue mobile app.

Step 2: Create your account with a username and password, which you will use for each MyLABlue visit.

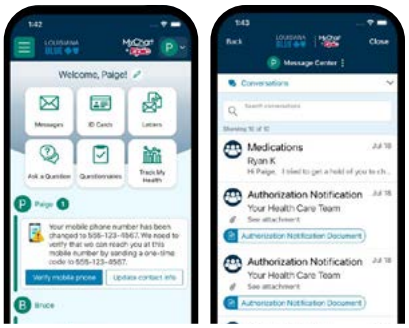
Treated Through Telemedicine

- Allergies
- Cold & Flu Symptoms
- Cough
- Ear Infection
- Pink Eye
- Prescription Refills
- Respiratory Infection
- Sinus Problems / Nasal Congestion
- Urinary Tract Infection
- And more!

Not Treated Through Telemedicine

- Sprains, broken bones or injuries requiring bandaging
- Anything that needs a hands-on exam
- Anything that needs a lab test or X-ray
- Chronic conditions

Please note, virtual providers are not intended to replace a primary care physician and do not treat chronic conditions (like diabetes) or medical emergencies (such as chest pain; severe burns; or head, neck or back injuries). In addition, virtual providers are unable to provide medical certifications for disability claims, leaves of absence or work-related injuries.



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HEALTH SAVINGS ACCOUNTS

What is an HSA?

A Health Savings Account (HSA) is a tax-advantaged account designed for individuals with high-deductible health plans (HDHPs). Contributions to an HSA can be made by both the employee and the employer, and these funds can be used to pay for qualified medical expenses such as doctor visits, prescriptions, and dental care.

To qualify for an HSA, you must be enrolled in a high-deductible health plan such as ZCSD's Blue Saver HDHP, have no other health coverage, not be enrolled in Medicare, and not be claimed as a dependent on someone else's tax return.

Save Money on your Taxes!

$100 from your paycheck

	Taxes Paid	Leftover for Medical Expenses
***Without* HSA**	$30	$70
With HSA	$0	$100

Key Benefits

1. **Triple Tax Advantage:** Contributions are made pre-tax, money in the account grows tax-free, and withdrawals for qualified medical expenses are tax-free.
2. **Flexibility:** Unlike Flexible Spending Accounts (FSAs), **HSAs are not "use-it-or-lose-it."** Unused funds roll over year to year and can be invested to grow over time.
3. **Portability:** HSAs are owned by the employee, meaning the account stays with you even if you change jobs or retire.

What can I use my HSA for?

Your Health Savings Account (HSA) can be used to pay for a wide range of qualified medical expenses. Here are some examples of qualified expenses:

- Doctor Visits
- Prescription Medications
- Dental Care
- Vision Care
- Medical Equipment
- Mental Health Services
- Preventive Care
- Over-the-Counter Medications

ZCSD Contribution to your HSA

If you enroll in the Blue Saver HDHP, ZCSD will contribute **$1,500** for employee only, **$2,250** for +child(ren) or +spouse coverage, or **$3,000** for family coverage.

ZCSD's contribution is included in the IRS maximum contribution of $4,400 for individuals and $8,750 for families. Individuals aged 55 and older can make an additional catch-up contribution of $1,000.

First Time Enrollees: To support your transition into the HDHP

ZCSD will contribute 33% of the total annual employer contribution for the tier in which you are enrolled to your HSA on September 1. This gives you immediate access to funds while your own semi-monthly contributions begin to grow.

Starting January 1st, ZCSD will prorate the remaining employer contribution and distribute to your HSA monthly.

		First Time Enrollees:		*Returning Participants:*	
ZCSD's Contribution	**Plan Year Contribution**	**September 1 Lump-Sum**	**Jan-Aug Monthly Contributions**	**September 1 Lump-Sum**	**Sept-Aug Monthly Contribution**
Employee Only	$1,500	$500	$125.00	n/a	$125.00
Employee + Spouse	$2,250	$750	$187.50	n/a	$187.50
Employee + Child(ren)	$2,250	$750	$187.50	n/a	$187.50
Family	$3,000	$1,000	$250.00	n/a	$250.00

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

New Programs with Sun Life:

Kid Smile Complete

ZCSD's new dental plan features **100% coverage** and no deductible for dependent children under age 13. Includes preventive, basic, and major services!

Preventive Rewards Program

The dental plan covers a calendar maximum of $2,000 per covered person. By receiving annual preventive care, increase your maximum benefit by **up to $1,500** for the following plan year!

Monitor your rollover balance and calendar maximum on the Sun Life mobile app.

New Carrier Sun Life

DENTAL COVERAGE

Sun Life Dental PPO

The Sun Life Dental PPO Plan offers you flexibility to see the provider of your choice each time you seek dental care. You can find a Sun Life network dentist online at **www.sunlife.com,** or by calling 1-800-786-5433.

	Sun Life Dental PPO In-Network, You Pay:
Calendar Year Deductible (Per Individual / Per Family)	$50 / $150
Calendar Year Maximum	$2,000 per covered person
Preventive Care - Type 1 Routine exam, bitewing x-rays, full mouth/panoramic x-rays, periapical x-rays, cleanings, fluoride, sealants, space maintainers	No charge, deductible waived
Basic Services -Type 2 Restorative amalgams/composites, endodontics (surgical/non-surgical), periodontics (surgical/non-surgical), denture repair, simple/complex extractions, anesthesia	Deductible, then 20%
Major Services Onlays, crowns, crown repair, implants, prosthodontics (fixed bridge, removable complete/partial dentures)	Deductible, then 50%
Orthodontic Services Available to dependent child(ren) to age 26	Deductible, then 50% $2,000 Lifetime Maximum per Child
Orthodontic Lifetime Maximum	$2,000

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Semi-Monthly Plan Cost (x24)	Sun Life Dental PPO
Employee Only	$25.07
Employee + Spouse	$49.66
Employee + Child(ren)	$55.67
Family	$79.21

Watch a brief video on how to read an Explanation of Benefits (EOB).

Out-of-Network Providers & Balance Billing

Under the Sun Life Dental PPO, the plan pays the same amount to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers **may result in significant patient liability.**

New Carrier Sun Life

VISION COVERAGE

Sun Life Vision Plan

Choose a Sun Life doctor or any other provider from the Sun Life Network. To find a Sun Life provider, visit **www.sunlife.com** or call 1-800-786-5433. At your appointment, tell them you have Sun Life. There's no ID card necessary. Sun Life will handle the rest—there are no claim forms to complete when you see an in-network provider.

	Sun Life Vision Plan	
	In-Network	**Out-of-Network**
Eye Exam (every 12 months)	$10 copay	$45 allowance
Standard Plastic Lenses (every 12 months) Single / Bifocal / Trifocal / Lenticular	$25 copay	$30 / $50 / $65 / $100 allowance
Frames (every 24 months)	$150 allowance, 20% off remaining balance $80 allowance at Costco	$70 allowance
Contact Lenses (every 12 months in lieu of standard plastic lenses) Fit / Follow-Up Exam Elective Medically Necessary	 $60 allowance, 15% savings on exam $150 allowance Plan pays 100% after $25 copay	 No benefit $105 allowance $210 allowance

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Semi-Monthly Plan Cost (x24)	Sun Life Vision Plan
Employee Only	$3.62
Employee + Spouse	$7.20
Employee + Child(ren)	$6.66
Family	$10.25

New Carrier The Hartford

BASIC LIFE AND AD&D INSURANCE

Basic Life Insurance

Life insurance provides financial protection for your family in the event of your passing. ZCSD offers all employees life and accidental death and dismemberment insurance through The Hartford. ZCSD covers the full cost of this benefit.

Basic Life Benefit Amount: 1.5x annual salary up to $130,000

AD&D Benefit Amount: Equal to Life amount

There is no age reduction in your benefit. Benefits terminate upon retirement.

Plan Cost: 100% Employer Paid

New Carrier The Hartford

VOLUNTARY LIFE AND AD&D INSURANCE

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by The Hartford.

New hires and employees currently enrolled in coverage may elect or increase coverage up to the Guaranteed Issue amount without answering health questions. Employees who previously declined or waived coverage will be required to complete health questions and may be subject to underwriting approval before coverage becomes effective.

Employee Voluntary Life / AD&D Insurance

Benefit Amount: increments of $10,000 up to the lesser of 5x salary or $500,000
Guarantee Issue: $180,000
AD&D Amount: 100% of life benefit amount
Age Reduction Schedule: 35% at age 70, 50% at age 75, and 70% at age 80

Spousal Voluntary Life / AD&D Insurance

Benefit Amount: increments of $5,000 up to $250,000
Guarantee Issue: $50,000
AD&D Amount: 100% of supplemental life benefit amount
Spouse cost is based on employee's age

Dependent Child Voluntary Life / AD&D Insurance

Benefit Amount: $10,000

Employee-Paid; Group Rate Based on Age

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). For information on Portability, please contact ZCSD's Benefits Helpline.

Life/AD&D Monthly Premium

Age	Rate per $1,000
Under 35	$0.10
35-39	$0.13
40-44	$0.18
45-49	$0.26
50-54	$0.37
55-59	$0.64
60-64	$0.93
65-69	$1.47
70-74	$2.54
75+	$4.49
Dependent Child(ren)	$0.24

Voluntary Life Premium Calculation: Coverage Amount ÷ $1,000 × Rate = Monthly Premium

New Carrier The Hartford

VOLUNTARY DISABILITY INSURANCE

Voluntary Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability that extends for more than 30 consecutive days, ZCSD provides short-term disability (STD) through The Hartford. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After: 30 days

Benefit Amount: 60% of earnings up to $2,500 / week

Benefit Duration: 22 weeks

Employee-Paid; $0.250 per Month per $10 of Weekly Benefit

Pre-Existing Condition Limitations

The Hartford will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician before your most recent effective date of insurance.

For both Short-Term and Long-Term Disability, the pre-existing condition is 3/12 meaning any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

Watch a brief video on Disability Insurance and how it works.

Voluntary Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

Benefits Start After: 180 days

Benefit Amount: 60% of predisability monthly earnings

Maximum Benefit: $6,000 / month

Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Employee-Paid; Group Rate Based on Age

Age	Rate per $100 of Monthly Benefit
<25	$0.049
25-29	$0.096
30-34	$0.150
35-39	$0.212
40-44	$0.306
45-49	$0.395
50-54	$0.606
55-59	$0.760
60-64	$0.798
65+	$0.838

Need to take extended leave? Watch a brief video on FMLA leave.

New Carrier The Hartford

EMPLOYEE ASSISTANCE PROGRAM

Supporting You Through Life's Challenges

Life's challenges don't always fit neatly into a workday—or come with a clear roadmap. That's why The Hartford provides access to two valuable support programs: **Ability Assist®** offers confidential counseling and work-life resources to help you manage everyday challenges, while **HealthChampion®** provides expert healthcare advocacy and guidance when you or a family member are facing a medical issue, disability, or complex healthcare decision.

Confidential counseling and healthcare advocacy services at no cost to you!

Whether you need emotional support, assistance with financial or legal matters, or help understanding healthcare options and benefits, Ability Assist® and HealthChampion® are here to provide assistance every step of the way.

Ability Assist® EAP Services

The Hartford's Ability Assist® Employee Assistance Program (EAP) provides employees and their household members with confidential, professional support to help manage personal, family, financial, legal, and workplace challenges. Services are available 24/7 and are designed to improve overall well-being and resilience.

- 24/7 access to master's-level counselors for confidential guidance and support.
- Emotional wellness assistance for stress, anxiety, grief, relationship concerns, and other personal challenges.
- Up to three in-person counseling sessions per issue, per year at no additional cost.
- Unlimited telephone consultations for financial, legal, and work-life concerns.
- Referrals to community resources and specialists when additional support is needed.

HealthChampion® Healthcare Navigation

Included as part of Ability Assist®, HealthChampion® helps employees navigate the complexities of the healthcare system, especially during a serious illness, disability, or major medical event.

HealthChampion specialists can help:

- Understand health plan benefits and coverage.
- Compare treatment options and estimate healthcare costs.
- Resolve claims, billing, and administrative issues.
- Prepare for doctor's visits, tests, procedures, and surgeries.
- Coordinate care and connect employees with appropriate healthcare resources and support groups.
- Advocate for timely and fair resolution of healthcare-related concerns.

How to Access

Call today or go online for a variety of resources. HealthChampion® is integrated with Ability Assist® so it's easy to access both services through the same contact information and registration portal listed below:

Phone: 800-96-HELPS (800-964-3577)

Online Registration: www.guidanceresources.com

Company Code: **HLF902**

Company Name: **ABILI**

Watch a brief video on Employee Assistance Programs (EAPs).

Watch a brief video on Managing Stress & Mental Health.

New Carrier The Hartford

THE HARTFORD ADDITIONAL BENEFITS

In addition to financial protection through Life Insurance, employees and their families have access to a comprehensive suite of support services designed to provide guidance, convenience, and peace of mind throughout life's most challenging moments.

Bereavement, Funeral Planning & Support

Through The Hartford's partnership with Empathy®, employees and beneficiaries receive personalized support before and after a loss, including:

- Dedicated care managers and grief support specialists
- Will preparation services supported by licensed attorneys
- Funeral planning assistance and step-by-step guidance
- Estate, probate, and after-loss support
- Document storage and personalized checklists
- Obituary-writing assistance
- Account and subscription closure support
- Online resources and mobile app access for beneficiaries

Website: empathy.com/partner/hartford

Registration: join.empathy.com/hartfordcare

Email: hartford@empathy.com

Empathy Bereavement Services: 1-270-681-1364

Funeral Planning & Will Preparation: 1-229-544-2332

Travel Assistance & Identity Theft Support

Support and resources when traveling more than 100 miles from home for up to 90 days:

- Emergency medical assistance and referrals
- Medical evacuation and repatriation services
- Lost document and luggage assistance
- Emergency travel arrangements and cash assistance
- Identity theft education, monitoring support, credit review, fraud assistance, and card replacement services

U.S. & Canada: 1-800-243-6108 (toll-free)

Outside U.S.: 1-202-828-5885

Email: assist@imglobal.com

Bereavement services for your beneficiaries, will preparation, travel assistance, identity theft protection, and more!

Additional Beneficiary Support Features

The Hartford's Life Essentials program also includes:

- Online beneficiary management and updates
- Beneficiary checklists to help with final arrangements
- Compassionate condolence outreach and grief guidance
- Children's bereavement resources, including "The Healing Book"
- Expedited claims processing for qualifying circumstances
- Flexible claim payment options through the Safe Haven® program

These services are included to help employees and their loved ones navigate health challenges, travel emergencies, financial and legal matters, and end-of-life planning with confidence and support.

RETIREE BENEFITS

The Zachary Community School Board shall contract with a health care provider for health, hospitalization, and life insurance benefits for its eligible employees, retirees, and/or their spouses and children.

The School Board may pay any portion of an employee's premium it so designates. Employees hired by the Zachary Community School District shall be expected to work a **minimum of three (3) years** before leaving the system.

Health Insurance

You and your covered dependents can continue the health, dental, and vision benefits after you retire, but be advised that if you drop coverage on a dependent or yourself, you cannot re-enroll in that benefit. The School Board will continue to contribute a portion of your medical premium. The vesting schedule and worksheet will be provided to you.

Medical Vesting Schedule

Group A: 100% Vested Retiree and Dependent(s)

- Retirees hired **before** 2007 **and** enrolled in the health plan prior to January 1, 2007, will be 100% vested along with their dependents.

Group B: 100% Vested Retiree and 50% Dependent(s)

- Retirees hired **before** 2007 and **not** enrolled in the health plan prior to January 1, 2007, or those hired after 2007 will be vested as follows:
  - Group B Employee Vesting Schedule:

Completed years of employment	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
% of employers portion of premium	0	0	0	10%	20%	30%	40%	60%	80%	100%

  - Group B Dependent's Vesting Schedule:

Completed years of employment	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
% of employers portion of premium	0	0	0	0%	0%	0%	0%	0%	0%	50%

- Vesting will begin based on the employee's latest fulltime hire date.

Life Insurance

From the time hired, an employee shall receive life insurance coverage on an annual basis from the School Board of 1½ times the salary earned at the time of retirement. The maximum benefit for all life insurance coverage shall be $130,000.

For employees hired on or after August 1, 2019, an employee who has served a minimum of five (5) consecutive years of service at the time of retirement shall receive life insurance coverage of 1½ times the salary earned at the time of retirement, in accordance with the reduction schedule to the right.

Attained Age	Life Benefit Reduction
Age 70, but less than 75	65% of original amount
Age 75, but less than 80	50% of original amount
Age 80 and over	30% of original amount

Life Insurance Benefits for any insured retiree will automatically reduce on the policy anniversary date coinciding with or next following attainment of the ages shown.

Other Benefits

Disability coverage will end when you retire, however you will be able to continue Voluntary Life, Critical Illness/Cancer and Long-Term Care coverage.

Instructions, Forms, and Rates are included in the Retiree Packet you will receive upon notification of your retirement.

VOLUNTARY CRITICAL ILLNESS INSURANCE

The following voluntary benefit can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Covered Critical Illnesses

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Sudden cardiac arrest
- Invasive cancer –all breast cancer is considered invasive
- Non-invasive Cancer (25%)
- Skin Cancer
- Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement

Be Well Benefit

Each year, each family member who has Critical Illness coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings

Who can get coverage?

You: Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.

Your Spouse: Spouses can only get 100% of the employee coverage amount as long asyou have purchased coverage for yourself.

Your Children: Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.

Employee-Paid; Group Rate Based on Age

	Employee Coverage			Spouse Coverage		
Age	$10,000	$20,000	$30,000	$10,000	$20,000	$30,000
under 25	$3.40	$6.80	$10.20	$3.40	$6.80	$10.20
25 - 29	$4.30	$8.60	$12.90	$4.30	$8.60	$12.90
30 - 34	$5.10	$10.20	$15.30	$5.10	$10.20	$15.30
35 - 39	$6.50	$13.00	$19.50	$6.50	$13.00	$19.50
40 - 44	$8.30	$16.60	$24.90	$8.30	$16.60	$24.90
45 - 49	$10.70	$21.40	$32.10	$10.70	$21.40	$32.10
50 - 54	$13.40	$26.80	$40.20	$13.40	$26.80	$40.20
55 - 59	$17.80	$35.60	$53.40	$17.80	$35.60	$53.40
60 - 64	$27.80	$55.60	$83.40	$27.80	$55.60	$83.40
65 - 69	$37.10	$74.20	$111.30	$37.10	$74.20	$111.30
70 - 74	$50.50	$101.00	$151.50	$50.50	$101.00	$151.50
75 - 79	$71.30	$142.60	$213.90	$71.30	$142.60	$213.90
80 - 84	$99.30	$198.60	$297.90	$99.30	$198.60	$297.90
85+	$148.70	$297.40	$446.10	$148.70	$297.40	$446.10

For a full list of coverages and specific benefit information, please refer to the applicable insurance contract.

LOUISIANA BLUE

MEDICARE ADVANTAGE

This benefit is offered to employees and their spouses that are Medicare eligible and have both Medicare A and B. When retiring from Zachary, you will automatically be moved into this Medicare Advantage plan when you become Medicare eligible.

Blue Advantage PPO Plan - BCBS of Louisiana

***Effective 1/1/2026 to 12/31/2026**

Any retiring employee and qualified dependent who qualify for Medicare coverage **will be required to obtain Medicare Part A and Part B** as the primary coverage for their retirement health insurance. Retirees will have the Medicare Advantage plan available to them for enrollment at the same time they are eligible for Medicare. No other medical plan options will be available through ZCSD.

Medical Benefits	In-Network:	Out-of-Network:
Annual Deductible	$0	$0
Out of Pocket Maximum (Does not include Rx)	$1,000 Combined In- & Out-of-Network	
Preventive Care	$0 copay	$0 copay
Doctor Visits		
Primary Care Provider	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay
Urgent Care	$0 copay	$0 copay
Diagnostic Services/ Labs/Imaging	$0 copay	$0 copay
Inpatient Hospital	$0 copay	$0 copay
Ambulance Services		
Ground Ambulance	$0 copay	$0 copay
Air Ambulance	$0 copay	$0 copay
Emergency Care	$50 copay, waived if admitted	

Dental Benefits	In-Network:	Out-of-Network:
Annual Maximum Benefit	$2,000 combined coverage amount	
Preventive Services Oral Exams, Cleanings, X-Rays, Fluoride	$0 copay	$0 copay
Comprehensive Services	$0 copay	$0 copay

Prescriptions	One Month	Two Month	Three Month
Preferred Retail & Mail Order			
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generics	$12	$24	$0
Tier 3: Preferred Brand	$45	$90	$135
Standard Retail & Mail Order			
Tier 1: Preferred Generic	$10	$20	$30
Tier 2: Generics	$18	$36	$54
Tier 3: Preferred Brand	$47	$94	$141

Vision Benefits	In-Network:	Out-of-Network:
Exam	$0 copay	$0 copay
Diabetic Eye Exam	$0 copay	$0 copay
Eyeglasses or contacts after cataract surgery	$0 copay	$0 copay
Glaucoma Screening	$0 copay	$0 copay
Supplemental Eyewear Contact lenses Eyeglasses Eyeglass Frames Eyeglasses (lenses and frames) Upgrades	$0 copay up to a *$300 combined maximum benefit every year	$40 copay

Hearing Benefits	In-Network:	Out-of-Network:
Hearing Exam	$0 copay	$0 copay
Fitting-Evaluation for Hearing Aids	$0 copay	$0 copay
Hearing Aids	$0 copay up to a *$800 maximum benefit every year	$0 copay

For a full list of coverages and specific benefit information, please refer to the ZCSD Retiree Benefits Guide or the applicable insurance contract.

Blue Advantage Flex Card

*The $300 vision allowance and *$800 hearing allowance will be loaded on your Blue Advantage Flex Card.

In addition, $200 per year ($50 per quarter) will be loaded on your Flex Card to use for over-the-counter (OTC) health-related products ($50 allowance per quarter) and must be used before the end of the quarter it was issued or you lose it.

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GLOSSARY OF TERMS

Watch a brief video reviewing key benefit-related terms.

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Home Health Care: Health care services a person receives at home.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

ANNUAL NOTICES

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in ZCSD-sponsored health and welfare benefit plan are reminded that ZCSD's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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 provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic 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, ZCSD asks Employees not to provide any genetic information when providing or responding to a 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.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

ANNUAL NOTICES CONTINUED...

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including spouse) 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 for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

HEALTH INSURANCE MARKETPLACE

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in ZCSD's medical plan, then PPACA may have little effect on you. ZCSD's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by ZCSD, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis.
(See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in ZCSD's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 1-800-318-2596.

ZACHARY
COMMUNITY SCHOOL DISTRICT

Your Benefits Helpline: 1-225-336-3274 ZacharySchools@AJG.com