West Lafayette
Community School Corporation

Employee Benefit Guide for January 1, 2026 – December 31, 2026

Building on Excellence

POLICY STATEMENT



West Lafayette School Corp is proud to offer and administer benefit programs that provide employees with competitive and comprehensive benefits. Benefits include medical, dental, vision, long-term disability, life and accidental death and dismemberment insurance and an employee health center.

A GUIDE TO YOUR BENEFITS

This Benefits Guide is designed to introduce you to the benefits available at West Lafayette and to remind you of the procedures and deadlines for enrollment in each plan.

This booklet contains useful information designed to help you understand your benefits and how to use them. This booklet is intended to be a summary of the West Lafayette Employee Benefits Plan information only and is not intended to be a Summary Plan Description. In the event of any discrepancy between this booklet and the actual plan documents or administrative procedures under which the Plans operate, then such plan documents or administrative procedures, shall govern. West Lafayette reserves the right to change, amend, or terminate the Plans at any time.

This Benefits Guide is only one of the many sources of information available to you. Toll-free numbers and internet addresses are listed in the Benefit Plan Contact Information section. You can also find benefit documents in the Forms Library of the benefit portal. You may call the Business Office whenever you have a question regarding West Lafayette's benefit plans.

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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QUESTIONS?



Contact West Lafayette Central Office at (765)746-1602 with any questions.

CONTACT INFORMATION

Plan	Carrier	Phone	Website/Email
Medical Dental Vision	Anthem	800-619-6164 844-729-1565 866-723-0515	www.anthem.com
Prescriptions	CarelonRx	833-419-0530	www.anthem.com
24/7 Telemedicine	First Stop Health	888-691-7867	firststophealth.com
LTD, Life and AD&D Insurance	National Insurance Services	800-627-3660	alodewegen@nisbenefits.com
Voluntary/Worksite Benefits	Madison National Life	800-356-9601, ext 2410	MNLCustomerCare@madisonlife.com
Health Savings Account Flexible Spending Account Dependent Care Account	P&A Group	716-852-2611	padmin.com
Employee Assistance Program	National Insurance Services	866-451-5465	bit.ly/eap-nis Company Code: NIS

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LOG IN & SELF-ENROLL

ONLINE BENEFITS ENROLLMENT INSTRUCTIONS
FOR NEWLY ELIGIBLE EMPLOYEES

1 VISIT

https://www.benselect.com/WLCSC

2 LOGIN

- Enter 9 Digit Social Security Number: no dashes or spaces
- Enter 6 Digit PIN: Last 4 digits of SSN & last 2 digits of birth year (ex. last 4 of SSN are 1234 and birth year is 1980, PIN is 123480)

3 ENROLL

- **Update** beneficiaries and dependents
- **Choose** the benefits that are right for you

USEFUL TIPS

- **Gather** dependent information prior to logging into system
- **Choose** an election for each benefit, then click the **“Next”** button
- **Add** dependent and beneficiary information
- **Sign** Electronically by re-entering your 6 digit PIN
- **Verify** enrollment status shows **“100% complete"**



Don’t wait until the last minute to enroll!!

WHO IS ELIGIBLE?

You must enroll within 30 days of eligibility date.

The benefits described in this Guide are offered to all full-time eligible employees in an eligible position who work at least 30 hours per week (27.5 hours for Bus Drivers), every week.

Voluntary Benefits are listed towards the back of this guide and are offered to all eligible employees who work at least 20 hours per week.

Benefits are effective on the 1st of the month following 1 month of service.

DEPENDENTS YOU CAN COVER UNDER THE BENEFITS PLAN:

- Natural Children- from birth through the end of the year of their 26th birthday
- Adopted Children- from birth through the end of the year of their 26th birthday
- Children who you are legally responsible for providing coverage-from birth through the end of the year of their 26th birthday

Dependent children can be covered without age restrictions if the child is incapable of self-support due to an illness that occurred prior to age 26. You may be asked to provide evidence that your dependents meet the eligibility requirements, such as a birth certificate, marriage license, or adoption papers.

Should you leave West Lafayette for any reason, your coverage will terminate based upon deduction status.

ENROLLMENT CHECKLIST

- ✓ **READ this Benefits Enrollment Guide**
- ✓ **REVIEW your current benefits in the benefit portal.**
- ✓ **ENROLL for 2026 benefits. You will be able to enroll on your own or make an appointment. Please have dependent SSN & date of birth for all enrollees.**
- ✓ **CONTACT YOUR BENEFITS SPECIALIST if you have questions or need assistance with enrollment.**
- ✓ **BE PREPARED if making changes due to a life event. You may be asked to provide proof.**

If you or your children are or could be eligible for Medicaid or the Children's Health Insurance Program (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. More information can be found on the Oracle HCM enrollment site.

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CHANGING YOUR BENEFIT ELECTIONS MID-YEAR

IRS regulations and federal laws govern the changes you can make to your Benefit elections during a Plan Year. Generally, you are not allowed to change certain pre-tax options during the Plan Year except for specific family-related events such as:

- Gaining a dependent through marriage, birth or adoption of a child, etc.
- Losing a dependent through marriage, divorce, legal separation, death of a covered dependent, dependent gains eligibility elsewhere, etc.
- Change in spouse's employment affecting coverage
- A judgment, decree or court order

Changes to your benefits must be made within 31 days of your life event per IRS regulations.

Before your changes can be approved, proof of the life event may be requested by your local Benefits Specialist.

If you are adding or dropping a dependent from your benefit plans, you are required to make the change within 31 days. Please submit the appropriate documentation to your local Benefits Specialist within 31 days of the date of the event. Important Notice: IRS regulations require that any changes requested must be made within 31 days of the qualifying event and must be consistent with the event.

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MEDICAL PLANS

West Lafayette Offers Two Medical Plan Choices:

1.) Traditional PPO Health Plan w/ Copays (Preferred Provider Organization)

2.) High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

Under a PPO Plan you pay higher per pay premiums however; you have a flat copay for office visits and medications, as well as a lower deductible. Under a high deductible health plan, you pay lower premiums however; all health care expenses are paid out-of-pocket until the deductible is met. (A deductible is the amount of money you pay before the plan begins to pay on covered services). The out-of-pocket limit is the most you will pay in the plan year for covered services. Preventive visits are at no cost to you. The HDHP offers a Health Savings Account to help assist you in paying for your health care costs

Benefit Details	Traditional PPO In-Network	High Deductible w/HSA In-Network
Annual Deductible *(exclude Rx copays)* Single Family	 $1,000 $3,000	 $3,500 $6,000
Annual out-of-pocket maximum *(includes deductible & RX co-pays)*	$2,500 single coverage $5,000 family coverage	$3,500 single coverage $6,000 family coverage
Physician office visit	$20 copay	0% after deductible
Preventive care	covered at 100%	covered at 100%
Outpatient services	10% after deductible	0% after deductible
Hospital services	10% after deductible	0% after deductible
Urgent Care/Emergency room services	$25/$100 copay	0% after deductible
Mental Health/Substance Abuse	$20 copay	0% after deductible
Medications **30-Day Supply – Tier 1/2/3** **Home Delivery – Tier 1/2/3** **Prescription Deductible**	 $10/$20/$40 $20/$40/$120 $4,650 person/$9,300 family	 Subject to Medical Deductible & Coinsurance No pharmacy deductible

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HEALTH SAVINGS ACCOUNT (HSA) 8

Benefits to an HSA include triple tax advantages:

1. **All contributions can be made pre-tax, decreasing your taxable income.**
2. **Earn money tax-free through investment or interest payments.**
3. **Pay for your qualified medical/dental/vision health care expenses money in your account.**

WLCSC contributes to your HSA annually*:

$2,000- Employee Only
$3,000- Employee Plus And Family

***WLCSC contributes on January 19 and October 4**

- **Control –** You can use the HSA to pay for any qualified medical expense.
- **Convenience –** You can elect to have money taken out of your paycheck through payroll.
- **Portability –** The money you contribute to the HSA rolls over from year-to-year if you do not use it. After you turn age 65, you can use the money for anything - not just health care expenses.
- **Investments –** The HSA is an interest-bearing account, and as your balance grows, you will be offered a range of investment options.

To participate in the Health Savings Account (HSA), you must be enrolled in the High Deductible Health Plan.

- **WLCSC will deposit half of $2,000/$3,000 into your account on the 2nd pay in January and 1st pay in October, if you enroll in the HDHP during annual enrollment and elect an HSA.**
- **Contributions into the account are excluded from gross income and not subject to employment taxes (e.g., FICA).**

The maximum annual contribution, including employee and employer contributions allowed by the IRS for 2026 is:

Coverage	IRS Maximum Contribution
Employee-only coverage	$4,400
Family coverage	$8,750
Age 55 and over	Additional $1,000 Catch-up contribution

- You may change your contribution to your HSA quarterly during the year as long as you have not met the IRS contribution limit for the year. You are responsible for that decision, and therefore should familiarize yourself with what qualified medical expenses are (defined in IRS Publication 502) and also keep your receipts in case you need to defend your expenditures or decisions during an IRS audit.
- If the money is used for anything other than qualified medical expenses, the expenditure is taxable and, for individuals who are not disabled or over age 65, subject to a 20% tax penalty.
- The IRS will not allow you to contribute dollars to your HSA account if you are enrolled in a Medicare Plan. This does not apply to spouses enrolled in Medicare.
- Once you enroll in the HSA, you will receive a debit card to pay for out-of-pocket health care expenses and an enrollment welcome kit that includes more detailed information about the HSA. When you use your debit card, you should maintain records of your health care expenses to verify that the expenses are for qualified services. If you decide to participate in the HSA, you should familiarize yourself with what qualified medical expenses are, as defined by IRS Publication 502. Visit the IRS Web site at www.irs.gov for more information.

Don't forget to designate your beneficiaries through the Steele Benefits portal.

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DENTAL PLAN

The dental plan is through Anthem Dental and uses the Anthem network of dentists. Network providers can be located by accessing the Anthem Dental website at **www.anthem.com/provider/dental/**

Dental Summary	
Preventive services ***(oral exam, X-rays, cleanings)***	This plan pays 100% of reasonable and customary covered expenses. There is no deductible to be met for preventive services.
Basic restorative services ***(fillings, simple extraction..,)***	The plan pays: 80% after deductible
Major services ***(bridge, partial, crown, dentures, root canals, oral surgery, anesthesia)***	50% after deductible
Orthodontia	50% after deductible
Calendar year deductible	$50 Single/ $150 Fam.
Maximum benefit per member per calendar year (excludes annual preventive services)	$1,000

If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.

VISION PLAN

In addition to eye exams, this plan also covers a portion of the costs of hardware, lenses and contacts. You may use a participating provider or any licensed provider, however your costs may be higher if you do not use a network provider. Network providers can be located by accessing the **Anthem** website and clicking 'Find Care' in the upper right corner at **www.anthem.com.**

Benefit Category	In Network	Out of Network
Exams (limited to one exam and one contact lens fitting/follow up within a 12-month period)	$10 Copay	Up to $42
Vision Material		
Standard Plastic Lenses (limited to one set of standard plastic lenses with a 12-month period)		
Single Vision **Bifocal Trifocal** **Lenticular**	$20 Copay $20 Copay $20 Copay	Up to $40 Up to $60 Up to $80
Frames (limited to one pair of frames within a 12-month period)	$150 Allowance; then 20% off balance	Up to $45
Contacts (1 set of lenses within a 12-month period)	Up to $140 allowance; then 15% off balance MedNec.- Covered in Full	Up to $105
Conventional		Up to $105
Disposable		Up to $105
Medically Necessary -		Up to $210
Other Add-Ons	20% off Retail Price	N/A

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First Stop Health



24/7 care when you need it.

Get convenient care for your body and mind — all via phone or video. West Lafayette provides First Stop Health to medical enrolled employees and their immediate family members. It costs $0!

On-demand doctor visits

Getting the care you need shouldn't be a pain. Board-certified doctors are available 24/7 via phone or video!

Diagnosis & treatment

Get immediate support, including prescriptions when appropriate* for:

- Sore Throat
- Cough
- Sinus Issues
- Skin Rash
- UTI
- Rx Refill*
- Pink Eye
- Fever
- Earache
- Cold & Flu
- Medical Questions
- And more!

Counseling for your mental health.

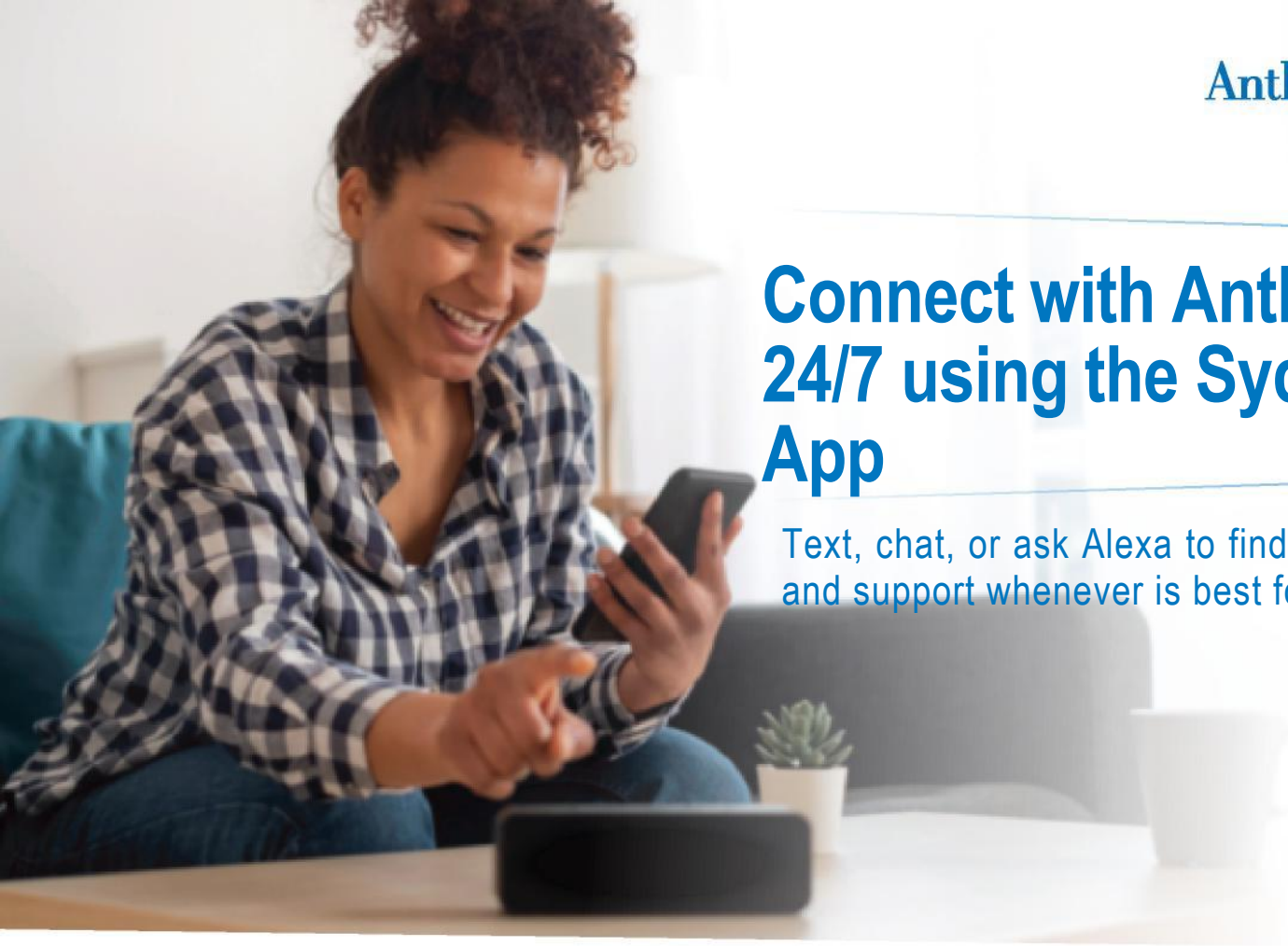
Use short-term, solution-focused counseling for anxiety, depression, grief and more.

*First Stop Health services are not intended to constitute a health plan. *Providers at First Stop Health do not prescribe controlled substances. Costs according to your medical plan may apply for prescriptions. For those under the age of 18, virtual counseling use will be considered on a case-by-case basis.*

Activate your account

Use the last 4 digits of your SSN to claim your account!

firststophealth.com
888-691-7867



Connect with Anthem 24/7 using the Sydney App

Text, chat, or ask Alexa to find answers and support whenever is best for you

When you have questions about your Anthem health plan, you can find answers in real time, in the way that suits you best. Anthem's digital tools ensure that help is available whenever you need it. Whether you prefer interactive chat, hands-free voice commands, or live chat, you now have solutions that make it easier for you to focus on your unique needs and priorities.

Sydney Health

The Sydney℠ Health mobile app provides quick access to your health plan information — all in one place. The app's interactive chat feature helps you navigate your benefits with greater ease. Simply type your questions in the app to find answers quickly. Sydney Health can also suggest resources to help you understand your benefits, improve your health, and save money.

How to use Sydney Health's interactive chat

Download the app

- Download the Sydney Health app from the App Store® or Google PlayTM.
- Register or log in to your account using your Anthem username and password.
- Look for the interactive chat feature icon, then type in your questions.

Use the Sydney Health interactive chat feature to:

- Search for doctors, hospitals, labs, and other health care providers in your plan.
- Check costs for care before you see a doctor.
- Pull up your digital member ID card.
- See what your plan covers.
- Find your deductible, copay, and share of costs.
- **Please see the following page for additional details on how to easily use Sydney**!

Discover how Sydney Health simplifies health care

Download and start using the app today.

Download on the App Store | Google play

Use your smartphone camera to scan this QR code.

Live Chat

Available on Sydney Health or **anthem.com**, our Live Chat tool enables you to chat in real-time with a representative who can answer your benefit questions or connect you with others who can help.

How to use Live Chat

Log in using Sydney Health or anthem.com:

1. For Sydney Health, go to the **Menu** tab and under *Get Support,* select **Start a live chat.**
2. For **anthem.com**, choose **Live Chat** under the *Support* tab.

Choose your chat topic:

Once you start a chat, select a topic or program to connect with a representative who can best help you. Topics include:

- 24/7 NurseLine
- Behavioral health
- Benefits, coverage, and claims
- Maternity and baby benefits
- Pharmacy

With more ways to reach us, we're making it easier for you to find the answers and support you need, right when you need it.

Anthem Skill for Alexa

Quick, hands-free help is here. The Anthem Skill works through Alexa-ready devices, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app. Say the words, "Alexa, ask Anthem ..." to start using the skill.

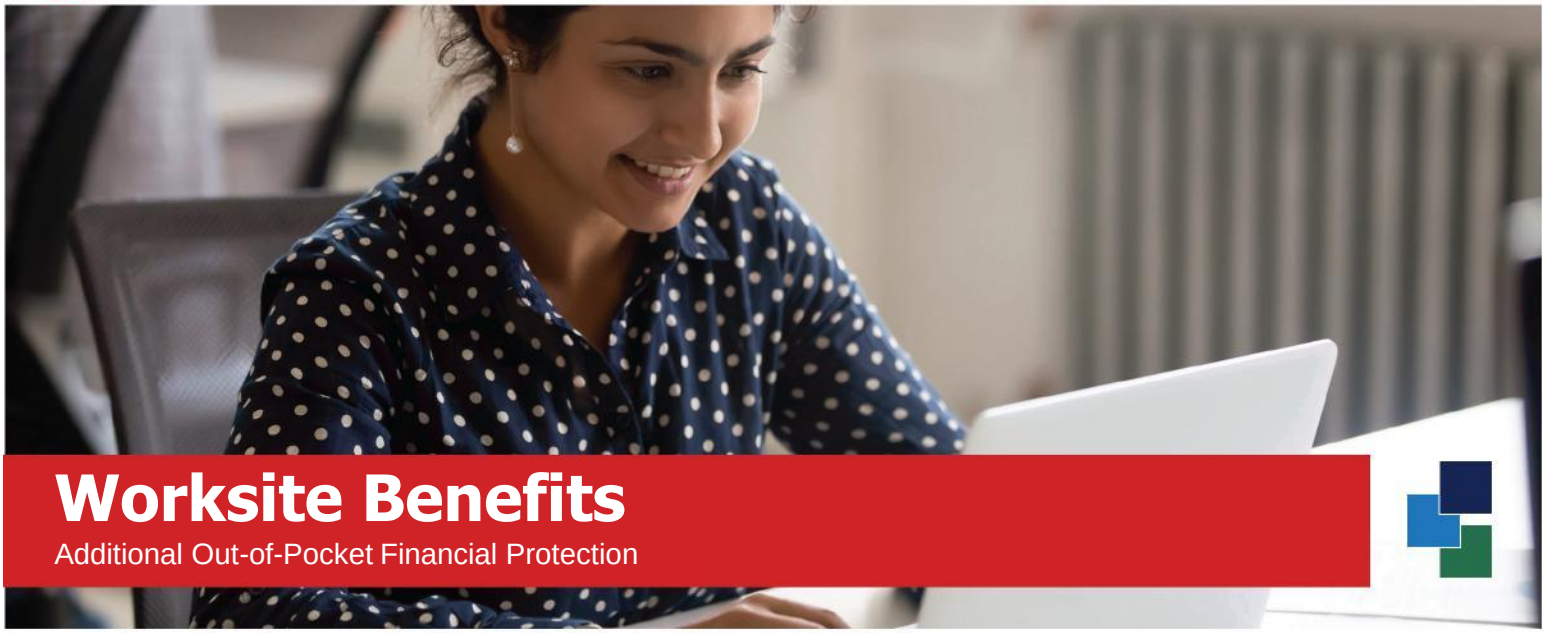
How to use Anthem Skill

Enable the Skill:

- Download the Amazon Alexa app from the App Store® or Google PlayTM.
- Go to **Skills and Games** and search for the **Anthem Skill.** Then tap **Enable to Use.**
- Enter your Anthem username and password to link the Skill with your Anthem account.
- Set up your Alexa voice profile and passcode if you haven't already.
- Ask Alexa for help by saying, "Alexa, ask Anthem ..."

Use the Skill to:

- Ask for your digital member ID card.
- Check your deductible and out-of-pocket maximum.
- Refill, renew, cancel, and check the order status of home delivery prescriptions.
- Access your spending account balance.
- Schedule a call with our Member Services team.
- Search for a doctor, specialist, or facility.
- Access claim information.
- Learn what a health care term means.



Worksite Benefits

Additional Out-of-Pocket Financial Protection

What Are Worksite Benefits?

Worksite benefits can help supplement your core health benefits by providing additional protection if you or your covered dependents suffer a covered accident, injury, or hospitalization. The benefit payments may help you cover out-of-pocket expenses not fully paid by regular health insurance. There are many reasons to take advantage of worksite benefits.

- Compliments high deductible health plans (HDHPs) by helping to limit your worries of having to pay for a high deductible while suffering an accident, illness, or hospitalization
- May serve as a way to supplement your health insurance coverage
- You can help mitigate your financial risks in the event an accident, illness, or hospitalization occurs
- You have the option to join a wellness plan which reimburses you each year for having certain tests and routine exams done

How Do Worksite Benefits Work (In a Nutshell)?

You can submit a claim and required documentation directly to the third-party administrator. Once approved, you usually receive a lump-sum payment. Check your policy to see what specific benefits are covered and pay out amounts.

Types of Worksite Benefits:

- Accident Insurance: Accident insurance will pay benefits for eligible specific injuries and events resulting from a covered accident.
- Critical Illness Insurance: If you are diagnosed with an eligible covered critical illness or specified disease, you can receive a lump-sum benefit to help pay for your out-of-pocket expenses.
- Fixed-Indemnity Insurance: This type of insurance will pay you a daily benefit if you have an eligible covered stay in a rehabilitation facility, hospital, or critical care unit.
- Life Insurance: Protect your loved ones if the unexpected happens. Life insurance provides additional term life coverage for you, your spouse, and your dependents.
- Disability Insurance: If you become sick, injured, or unable to work due to an eligible injury or physical disease, disability insurance provides a portion of your lost earnings. Long-term and short-term options are available.

To Elect These Coverages, Notify Steele Benefits During Your One-on-One Enrollment Meeting

Underwritten By:

Madison National Life
a Horace Mann company

PO Box 5008, Madison, WI 53705

Founded in 1961, Madison National Life Insurance Company, Inc is headquartered in Madison, the rapidly growing capital city of Wisconsin. Madison National Life is licensed in 49 states and specializes in group life, disability and specialty health insurance. The company is a wholly owned subsidiary of Horace Mann Educators Corporation (NYSE:HMN), the largest financial services company focused on providing America's educators and school employees with insurance and retirement solutions.

Group Term Life and Long Term Disability will be administered by National Insurance Services (Corporate Headquarters: 250 South Executive Drive, Suite 300, Brookfield, WI 53005-4273. Offices Nationwide: 800.627.3660) Accident, Critical Illness, Fixed Indemnity, Short-Term Disability, and Voluntary Term Life Insurance To Age 120 will be administered by NABCO (20 Valleystream Parkway, Suite 310, Malvern, PA 19355. (800) 537-4565. www.nabenefits.com)

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ACCIDENT

UNDERWRITTEN BY MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

SPECIALLY DESIGNED FOR THE EMPLOYEES OF:

West Lafayette Schools

Benefit Highlights

Benefit Payments Insured: 100% | Spouse: 100% | Child(ren): 100%
Accident Limit **2 Accidents** during each group policy year
Job Coverage **24-Hour**, both on and off the job
Benefit Waiting Period **0** days

Monthly Rates

	Rate
Employee	4.87
Employee + Spouse	9.95
Employee + Child	13.20
Family	20.42

Key Features

Premium Contribution Voluntary
Insurance Portability Enables Insureds who have been continuously covered for 12 months prior to termination and under age 60 to continue insurance with the required premium payment until the group policy terminates, or Insured attains age 80

Benefit Summary

Per Accident, Per Calendar Year

Benefit availability will vary by state

INITIAL CARE & TREATMENT	Transfusion of Blood, Plasma & Platelets	$75, limit 1
	Ground Ambulance	$100
	Air Ambulance	$250
	Outpatient Physician Office / Urgent Care	$20, limit 1 visit
	Emergency Room	$250 per visit, limit 1 per year
	Medical Appliances	$50
	Therapy Services (physical, speech, occupational)	$15 per visit, limit 1 visit
	Outpatient X-Ray	$$25
	Advanced Diagnostic Imaging	$$150
	Outpatient Surgery	$$100

This brochure is for Certificate of Insurance form number GACC-C-0819. For a complete list of benefits, limitations and exclusions, please see the Certificate of Insurance. **Not available in all states.**

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ACCIDENT

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SPECIALLY DESIGNED FOR THE EMPLOYEES OF:

West Lafayette Schools

Benefit Highlights

Benefit Payments Insured: 100% | Spouse: 100% | Child(ren): 100%
Accident Limit **4 Accidents** during each group policy year
Job Coverage **24-Hour**, both on and off the job
Benefit Waiting Period **30** days

Monthly Rates

	Rate
Employee	8.26
Employee + Spouse	17.44
Employee + Child	22.40
Family	35.19

Key Features

Premium Contribution Voluntary
Insurance Portability Enables Insureds who have been continuously covered for 12 months prior to termination and under age 60 to continue insurance with the required premium payment until the group policy terminates, or Insured attains age 80

Benefit Summary

Per Accident, Per Calendar Year

Benefit availability will vary by state

Initial Care & Treatment	Transfusion of Blood, Plasma & Platelets	$150, limit 1
	Ground Ambulance	$200
	Air Ambulance	$500
	Outpatient Physician Office / Urgent Care	$50, limit 1 visit
	Emergency Room	$250 per visit, limit 1 per year
	Medical Appliances	$100
	Therapy Services (physical, speech, occupational)	$25 per visit, limit 1 visit
	Outpatient X-Ray	$$50
	Advanced Diagnostic Imaging	$$150
	Outpatient Surgery	$$400

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CRITICAL ILLNESS INSURANCE

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Benefit Highlights

Benefit Amount **$10,000 - $20,000 - $30,000**
Insured: 100% | Spouse: 100% | Child(ren): 50%

Benefit Amount Multiplier* **2 times** the Critical Illness Benefit Amount
Benefit Separation Period** **0** days
Benefit Waiting Period **30** days

Monthly Rates - $10,000

	Rate
Employee	10.72
Employee + Spouse	22.08
Employee + Child	12.35
Family	23.28

Monthly Rates - $20,000

	Rate
Employee	21.45
Employee + Spouse	44.16
Employee + Child	24.70
Family	46.56

Monthly Rates - 30,000

	Rate
Employee	32.17
Employee + Spouse	66.24
Employee + Child	37.06
Family	69.85

Key Features

Premium Contribution Voluntary
Pre-Existing Conditions Exclusion 12 months prior to effective date / 12 months after effective date
Insurance Portability Enables Insureds who have been continuously covered for 12 months prior to termination, and under age 60, to continue insurance with the required premium payment until the group policy terminates or Insured attains age 80

This brochure is for Certificate of Insurance form number GCI-C-0519. For a complete list of benefits, limitations and exclusions, please see the Certificate of Insurance. **Not available in all states.**

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FIXED INDEMNITY

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West Lafayette Schools

Benefit Highlights

Premium Contribution Voluntary

Monthly Rates

	Rate
Employee	7.95
Employee + Spouse	15.91
Employee + Child	12.97
Family	21.35

Plan Summary

For Sickness and Accident

Benefit availability will vary by state

INPATIENT	First Day Hospital	$250 per day, limit 1 day per year
	Hospital Inpatient	$100 per day, limit 365 days per year
	Hospital Intensive Care Unit (ICU)	$200 per day, limit 180 days per year
	Inpatient Mental Health Disorder	$50 per day, limit 5 days per year
	Inpatient Substance Use Disorder	$50 per day, limit 5 days per year
	Inpatient Skilled Nursing Facility	$50 per day, limit 8 days per year
	Inpatient Surgical	$500 per day, limit 1 day per year
	Inpatient Anesthesiology	$100 per day, limit 1 day per year
SERVICES / SUPPLIES	Ground Ambulance	$100 per day, limit 1 day per year

This brochure is for Certificate of Insurance form number GFI-C-0720. For a complete list of benefits, limitations and exclusions, please see the Certificate of Insurance. **Not available in all states.**

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SPECIALLY DESIGNED FOR THE EMPLOYEES OF:

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Benefit Highlights

Premium Contribution Voluntary

Monthly Rates

	Rate
Employee	27.04
Employee + Spouse	54.08
Employee + Child	44.78
Family	73.18

Plan Summary

For Sickness and Accident

Benefit availability will vary by state

INPATIENT	First Day Hospital	$750 per day, limit 1 day per year
	Hospital Inpatient	$200 per day, limit 30 days per year
	Hospital Intensive Care Unit (ICU)	$400 per day, limit 30 days per year
	Inpatient Mental Health Disorder	$50 per day, limit 5 days per year
	Inpatient Substance Use Disorder	$50 per day, limit 5 days per year
	Inpatient Skilled Nursing Facility	$50 per day, limit 8 days per year
	Inpatient Surgical	$500 per day, limit 1 day per year
	Inpatient Anesthesiology	$100 per day, limit 1 day per year
OUTPATIENT	Physician's Office	$25 per day, limit 2 days per year
	Outpatient Diagnostic Laboratory	$15 per day, limit 1 day per year
	Outpatient Diagnostic X-Ray	$25 per day, limit 1 day per year
	Outpatient Diagnostic Advanced Studies	$50 per day, limit 1 day per year
	Outpatient Surgical	$250 per day, limit 1 day per year
	Outpatient Surgery Facility	$250 per day, limit 1 day per year
SERVICES / SUPPLIES	Ground Ambulance	$100 per day, limit 1 day per year

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SHORT-TERM DISABILITY

UNDERWRITTEN BY MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

SPECIALLY DESIGNED FOR THE EMPLOYEES OF:

West Lafayette Schools

Benefit Highlights

Elimination Period	**14 days** Injury / **14 days** Physical Disease (Sickness)
Maximum Benefit Period	**13 weeks**
Weekly Benefit	Benefits are elected in increments of $25, not to exceed the lesser of **60%** of your weekly Pre-disability Earnings or **$1,400**

Monthly Attained Age Rates per Weekly Benefit

Benefit	$100	$125	$150	$175	$200	$225	$250	$275	$300	$325	$350	$375	$400
18-39	6.57	8.21	9.86	11.50	13.14	14.78	16.43	18.07	19.71	21.35	23.00	24.64	26.28
40-49	8.21	10.26	12.32	14.37	16.42	18.47	20.53	22.58	24.63	26.68	28.74	30.79	32.84
50-59	10.45	13.06	15.68	18.29	20.90	23.51	26.13	28.74	31.35	33.96	36.58	39.19	41.80
60+	15.28	19.10	22.92	26.74	30.56	34.38	38.20	42.02	45.84	49.66	53.48	57.30	61.12

Age	$425	$450	$475	$500	$525	$550	$575	$600	$625	$650	$675	$700	
18-39	27.92	29.57	31.21	32.85	34.49	36.14	37.78	39.42	41.06	42.71	44.35	45.99	6.57
40-49	34.89	36.95	39.00	41.05	43.10	45.16	47.21	49.26	51.31	53.37	55.42	57.47	8.21
50-59	44.41	47.03	49.64	52.25	54.86	57.48	60.09	62.70	65.31	67.93	70.54	73.15	10.45
60+	64.94	68.76	72.58	76.40	80.22	84.04	87.86	91.68	95.50	99.32	103.14	106.96	15.28

Monthly rates per $100 of Weekly benefit

Key Features

Guarantee Issue	$700 per week
Rate Basis	Attained Age, based on employee's age at policy anniversary
Job Coverage	Non-Occupational, off the job only
Pre-Existing Condition Period	6 months prior to effective date / 12 months after effective date
Partial Disability Benefit	Pays up to 50% of the weekly benefit for up to 13 weeks
Integration	Pays in addition to Sick Pay for the first 10 days from the end of the Elimination Period, then pays up to 100% of Pre-Disability Earnings
Waiver of Premium	Premiums are waived while STD benefits are payable
Pregnancy	Covered the same as any Physical Disease (Sickness)
Insurance Portability	After at least 12 months of insurance, an Insured Person may continue insurance for up to 12 months if insurance under the Group Policy terminates

This brochure is for Certificate of Insurance form number STD-C-0617. For a complete list of benefits, limitations and exclusions, please see the Certificate of Insurance. **Not available in all states.**



Supplemental Group Term Life and AD&D Insurance

West Lafayette Community School Corporation

How much insurance is available?

Employee Supplemental Life and AD&D Insurance: Your employer provides you with the option to purchase additional Supplemental Life and AD&D insurance in increments of $10,000 up to a maximum of $500,000, not to exceed 5 times your Annual Salary or 7 times Annual Salary Basic and Supplemental Life insurance combined.

Dependent Spouse Supplemental Life: Your employer also gives you the opportunity to purchase Supplemental Life Insurance for yourSpouse in increments of $5,000 up to a maximum of $150,000 but no more than 50% of your employee's amount.

Dependent Child Supplemental Life Insurance: You may elect to cover an Eligible Child(ren) by purchasing Supplemental Life Insurance inthe amount of $10,000 (6 months to 19 years or 23 years if a Full-Time Student); (limited to $0 for children from birth through 14 days, and $1,000 for children 15 days to 6 months.)

Who is eligible for this insurance?

You are eligible to enroll if you are actively at work, a member of an eligible class, and meeting the minimum hour requirement.

Dependent Life Insurance: No person may be considered a Dependent of more than one Eligible Employee. No person can be insured as an Employee and as a Dependent.

NIS National Insurance Services

Madison National Life a Horace Mann company

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Are there any medical questions or tests needed to qualify for this insurance?

You may elect up to the Guarantee Issue amount without medical questions.

- **Employee**: up to $150,000 if under age 60; $10,000 if age 60-69; $0 if age 70 or older
- **Dependent Spouse**: up to $30,000 if under age 65; $5,000 if age 60-69
- **Dependent Child**: $10,000

Late enrollees and increases:
Enrollees electing insurance after 31 days beyond their eligibility date and those requesting an increase in insurance will require medical questions and approval by Madison National Life Insurance Company, Inc (MNL).

Will the insurance benefit ever reduce?

Employee Supplemental Life and AD&D: Reduces to 65% at age 65, 45% at age 70, 30% at age 75, and 20% at age 80 and will terminate at retirement.

Dependent Supplemental Life:

- Dependent Spouse Supplemental Life reduces to 65% at age 65 and will terminate at age 70.
- Dependent Child Supplemental Life will terminate when your child turns age 19 or 23 if a full-time student, or when the child becomes married; whichever comes first.

Who do I contact with questions?

Questions may be directed to National Insurance Services at 1-800-627-3660.

Administered by:

NIS
National Insurance Services

Corporate Headquarters:
300 North Corporate Drive, Suite 300
Brookfield, WI 53045
Offices Nationwide
800.627.3660

Underwritten by:

Madison National Life
a Horace Mann company

PO Box 5008, Madison, WI 53705

This brochure is not the insurance contract. It is a brief description of your insurance underwritten by Madison National Life Insurance Company, Inc. For complete details including all benefits, exclusions, and limitations, refer to the certificate of insurance GTL-C600-0608M-IN as provided to you by your employer.

Founded in 1961, Madison National Life is headquartered in Madison, the rapidly growing capital city of Wisconsin. Madison National Life is licensed in 49 states and specializes in group life, disability and specialty health insurance. The company is a wholly owned subsidiary of Horace Mann Educators Corporation (NYSE:HMN), the largest financial services company focused on providing America's educators and school employees with insurance and retirement solutions.

NIS
National Insurance Services
Madison National Life
a Horace Mann company

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Embedded Employee Assistance Program (EAP)

Confidential Support for You and Your Family – Anytime

Balancing work and life is not always easy, and your employer understands that. That's why, through National Insurance Services (NIS), you and your dependents have access to a no-cost, confidential EAP with 24/7 support by phone or online.

Whether you're facing everyday stress or a major life event, you can connect with a qualified consultant and access practical tools and resources tailored to your needs.

Expert Support When You Need It

The EAP provides guidance across a wide range of concerns, including:

- Emotional wellbeing
- Family and relationships
- Financial and debt concerns
- Workplace challenges
- Legal and consumer issues

How the EAP Works

Support is available 24/7, 365 days a year:

- Calls are answered by a master's-level clinician, not an automated system
- You'll receive immediate, in-the-moment support
- Clinicians guide your case from first contact through follow-up

Many concerns are resolved in a single call. If additional help is needed, you'll be connected to trusted, vetted resources.

Program Highlights

- Complements your existing benefits
- Confidential support for personal and workplace concerns
- Multiple access points: phone, email, chat, or web
- Available 24/7 at no cost to you and your dependents
- Unlimited issues per year
- Personalized intake with counselor support
- Online portal with articles, tools, and resources

Counseling and Coaching Services

- Up to 3 in-person or virtual counseling sessions
- Unlimited single-session therapy
- Up to 6 life coaching sessions for goals and personal growth

Additional Features

- LiveConnect: Real-time chat support
- Savings Center: Discounts on name-brand products
- Financial and Daily Living Tools: Budgeting and planning calculators
- LifeLines: Quarterly tips and insights
- Aware Mindfulness: Resources for stress, pain, and neurological challenges

Support for Everyday Needs

Confidential help is available for:

- Alcohol or Drug Dependency
- Child and Elder Care
- Education
- Daily Living Needs
- Career Guidance
- Relationship Concerns
- Stress Management
- Financial or Legal Issues

Accessing the EAP is Easy:

Toll-Free:
866.451.5465

Website: bit.ly/eap-nis
Company Code: NIS

Download the App:

Registration Code: 436646

©National Insurance Services

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

Dependent Care Flexible Spending Account (DCFSA) is a pre-tax benefit account used to pay for eligible dependent care services. This account can be used for expenses, such as daycare and preschool, for children under age 13. It can also be used for expenses related to care for a disabled spouse or disabled dependent of any age. It is a simple way for you to save money on a pre-tax basis while taking care of your family so that you can continue to work.

How it Works: During Open Enrollment, or a qualifying life event, you enroll in the DCFSA. At that time, you decide the weekly amount you want to contribute (2026 max contribution is $7,500). Contribution amounts will be deducted from your paycheck on a pre-tax basis then added to your DCFSA.

Eligibility? In order to be eligible for an account, you must meet one of the following per IRS regulations:
You and your spouse (if applicable) are employed.
If your spouse is not employed, then they must be looking for work or attending school on a full-time basis.

How much can I contribute? The IRS contribution limit for 2026 is $7,500. (Note: If your spouse has a DCFSA at their employer then your combined contributions cannot exceed the $7,500 limit).

Does my money roll over each year? The money in the account is "use it or lose it," so plan your contributions accordingly. Money left in the account at the end of the plan year is forfeited per IRS regulations.

When can I enroll? The Dependent Care Account is a pre-tax contribution and thus must follow IRS guidelines. This account can only be elected at your initial enrollment period, during Open Enrollment, or if you have a qualifying life event.

How do I use my contributions? There are multiple ways to use the money in your account.
You will receive a debit card in the mail.
You can submit claims online for reimbursement
Use the Recurring Dependent Care Form where you will submit one form per year for the day care provider you use.

Visit Steele Benefits for more information.

What are eligible expenses? Any child-care expense that is incurred while you are at work, such as:
Preschool and after-school care, Daycare providers, Summer day camps. Ineligible expenses include:

- Night-time babysitting (unless you work nights when the expenses are incurred)
- Overnight camps
- Expenses paid for private school (kindergarten and above)

Visit Steele Benefits for more information.

Who qualifies as a dependent under a DCFSA? A child under the age of 13 who resides with you and for whom you are entitled to a personal tax exemption as a dependent.
A spouse, parents, or other tax-dependent adults who reside with you and are mentally or physically incapable of self-care.

Can I use the DCFSA for healthcare expenses for my children? No. A DCFSA is to help you pay for childcare and elder care expenses so you can continue to work. You may use your Health Savings Account to pay for healthcare expenses.

Please refer to your policy for plan details.

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Certificate of Creditable Coverage You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from the plan, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in other coverage if you are age 19 or older.

Health Insurance Portability and Accountability Act (HIPAA) This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available for medical, dental, vision, and healthcare Flexible Spending Accounts from Human Resources.

Newborns' and Mothers' Health Protection Act Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of 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).

Genetic Information Nondiscrimination Act (GINA) The Genetic Information Nondiscrimination Act of 2008 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.

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 genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity and Addiction Equity Act (MHPAEA) The Mental Health Parity and Addiction Act of 2008 general 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 more Information regarding the criteria for medical necessity determinations made under your employers plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 765-746-1602.

Women's Health and Cancer Rights Act 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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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. Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact Benefits at 765-746-1602.

Michelle's Law When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact your plan administrator at 765-746-1602.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

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MEDICARE PART D CREDITABLE COVERAGE NOTICE

An Important Notice from West Lafayette 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 West Lafayette 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:

- 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.

West Lafayette has determined that the prescription drug coverage offered by the West Lafayette Welfare Benefit 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 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 West Lafayette coverage will not 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 West Lafayette 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 West Lafayette 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.

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).

Name of Entity/Sender: West Lafayette School Corp.
Contact--Position/Office: Benefits Coordinator
Address: 1130 N. Salisbury St. West Lafayette IN 47906
Phone Number: 765-746-1602

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PATIENT PROTECTION RIGHTS UNDER HEALTH CARE REFORM

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

If the plan generally requires 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem by calling the number on the back of your ID card.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem by calling the number on the back of your ID card.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).
However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 31 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, or placement for adoption.

Example: When we hired you, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 31 days from the date of your marriage.

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NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
CONTINUATION COVERAGE RIGHTS UNDER COBRA CONTINUED

You Must Give Notice of Some Qualifying Events For the 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.

How is COBRA 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.

How Long Does COBRA Coverage Last? COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.
Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

Disability extension of 18-month period of continuation coverage If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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, 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.

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Brown & Brown INSURANCE®

EMPLOYEE BENEFITS

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.