2024-2025 Employee Benefits Guide

Effective September 1, 2024 to August 31, 2025

Zachary Community School District

CADENCE Insurance
A Gallagher Company

Table of Contents

Benefits That Work for You

Zachary Community School District knows that it is important to provide quality benefit options for our employees and their dependents. This is your starting point to learn about your benefits - whether you're enrolling for the first time or reconsidering your benefits during the annual open enrollment period.

Enrollment Eligibility

Full-time employees of the ZCSD (excluding temprary workers) working at least 30 or more hours per week, are eligible for benefits on the first of the month following 30 days of employment.

Many of the plans offer coverage for eligible dependents, including:

- Your legal spouse
- Your children to age 26, regardless of student, marital, or tax- dependent status (including stepchildren, legally adopted children, children placed with you for adoption, or children for whom you are the legal guardian)
- Your dependent children over age 26 who are physically or mentally unable to care for themselves

When To Enroll

Other than during the designated open enrollment period, you can enroll in benefits or change your elections at the following times:

- 30 days prior to your initial eligibility date (as a newly hired employee)
- Within 30 days of experiencing a qualifying life event

Changing Benefits After Enrollment

You may pay your portion of your select coverages on a pre-tax basis. Thus, due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a qualifying life event, and election changes must be consistent with that event.

To request a benefits change, notify human resources (HR) within 30 days of the qualifying life event. Change requests submitted after 30 days cannot be accepted. You may need to provide proof of the life event.

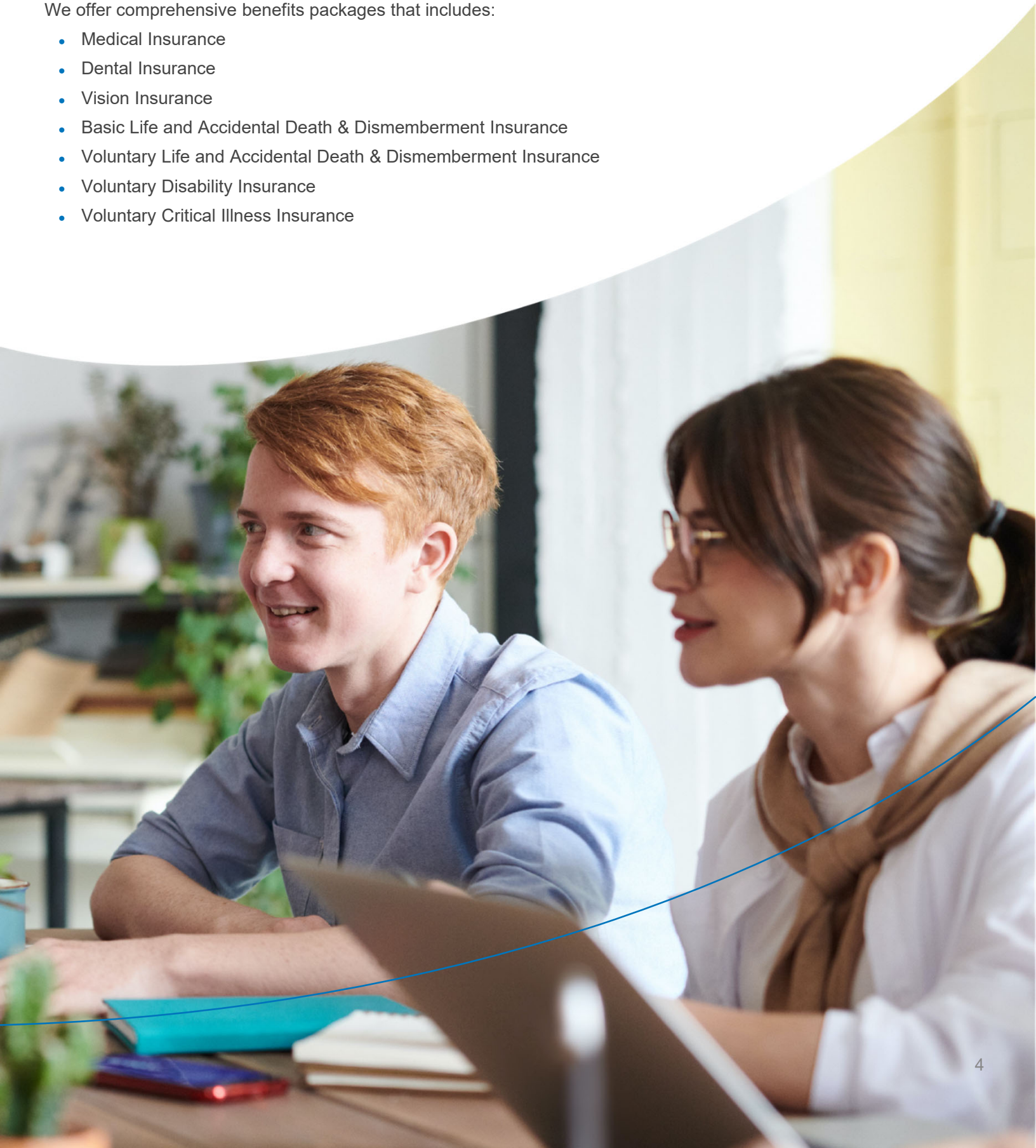
Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your child's eligibility for benefits
- Qualified medical child support order (QMCSO)

Benefit Options

We offer comprehensive benefits packages that includes:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Basic Life and Accidental Death & Dismemberment Insurance
- Voluntary Life and Accidental Death & Dismemberment Insurance
- Voluntary Disability Insurance
- Voluntary Critical Illness Insurance



Medical Insurance

Carrier: Blue Cross Blue Shield of Louisiana

- To locate an In-Network Provider, visit www.bcbsla.com.
- ***Remember to activate your Member Account!*** Access your digital ID Card anytime, locate a doctor or hospital, look at your claims, find out what insurance covers, and find out how much a prescription will cost. For more information, see the BCBS Activate your Member Account Flyer or visit www.bcbsla.com/activate.

THINGS TO CONSIDER

1. Do you prefer to pay more for medical insurance out of your paycheck, but less when you need care?
2. Do you prefer to pay less out of your paycheck, but more when you need care?
3. What planned medical services do you expect to need in the upcoming year?
4. Do you or any of your covered family members take prescription medications regularly?

Please refer to the official plan documents for additional information on coverage and exclusions.

	Plan A Blue HMO/POS **Louisiana Only Network**	Plan B Premier Blue **National Network**	Plan C Blue Saver HDHP **National Network**
Covered Benefits	In-Network	In-Network	In-Network
Annual Deductible: Individual/Family	$0 / $0	$500 / $1,500	$3,000 / $6,000
Out of Pocket Maximum: Individual/Family *(Includes coinsurance, copays & deductible)*	$2,250 / $4,500	$3,250 / $6,500	$5,000 / $10,000
Coinsurance *(PLAN PAYS)*	100%	90%	100%
Preventive Care	100% allowable	100% allowable	100% allowable
Quality Blue Primary Care Physician **Primary Care Physician** **Specialist**	$10 copay $25 copay $40 copay	$10 copay $25 copay $40 copay	100% after deductible 100% after deductible 100% after deductible
Telemedicine / BlueCare	$25 copay	$25 copay	$59 copay
Urgent Care	$40 copay	$40 copay	100% after deductible
Diagnostic Lab/X-Ray	Fully covered	Fully covered	Fully covered
MRI & CT Scan	Fully Covered	Fully Covered	Fully Covered
Emergency Room	$350 copay, waived if admitted	$350 copay, waived if admitted	100% after deductible
Inpatient Hospital Facility	$350 copay, 3 day max	90% after deductible	100% after deductible
Outpatient Hospital Facility	$350 copay	90% after deductible	100% after deductible
Pharmacy / Prescription Drug Costs Tier 1: Tier 2: Tier 3: Tier 4:	 $15 copay $40 copay $70 copay 10% Specialty, $150 max	 $15 copay $40 copay $70 copay 10% Specialty, $150 max	 Generic: 100% after deductible Brand: 0% after deductible

Pharmacy Tier Review: bcbsla.com/covereddrugs

Medical Insurance

Carrier: Blue Cross Blue Shield of Louisiana

What Are My Options for Care?

Be informed about your medical options so you are prepared.

	Conditions Treated	Your Cost and Time
Telemedicine Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app. www.BlueCareLA.com	• Allergies • Sinusitis • Colds and Flu • Rashes • Pink eye • Behavioral Health	• Total costs are lower than office visit • Register online to connect to a provider • No appointment needed • Seen immediately
Primary Care Physician The best place to receive routine or preventive care, track medications, or get a referral to see a specialist	• Non-emergency • Regular checkup • Screenings • Preventive care	• $25 copay POS Plan • $25 copay PPO plan • Full visit cost applies to deductible for HDHP • Appointment usually needed • May have to wait
Specialist Specialists treat complex health problems that primary care doctors may not be able to.	• Certain procedures • Complex or chronic conditions • Rare diseases • A condition won't improve	• $40 copay POS Plan • $40 copay PPO Plan • Full visit cost applies to deductible for HDHP • Appointment usually needed • May have to wait
Urgent Care For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	• Respiratory • Stomach pain • Low back pain • Infections	• $40 copay POS Plan • $40 copay PPO Plan • Full visit cost applies to deductible for HDHP • Costs are lower than an ER visit • No appointment needed • Wait times vary
Emergency Room Immediate treatment of critical injuries or illness	• Severe injuries • Chest pain • Broken bones • Difficulty breathing	• $350 copay POS Plan • $350 copay PPO Plan • Charges go towards deductible for HDHP • Highest costs • Wait times may be long, averaging over four hours • *Copay is waived if admitted

Before you seek care, ask, "Is this an urgent care center or ER?" and "Is this facility an in-network provider?"

Medical Insurance Rates

Carrier: Blue Cross Blue Shield of Louisiana

Medical Plan A Blue HMO/POS	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Total Monthly Premium	$940.25	$1,880.59	$1,739.35	$2,679.60
Employee Deduction (Semi-Monthly)	$150.44	$300.89	$278.30	$428.74

Medical Plan B Premier Blue	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Total Monthly Premium	$887.79	$1,775.57	$1,642.20	$2,529.98
Employee Deduction (Semi-Monthly)	$142.05	$284.09	$262.75	$404.80

Medical Plan C Blue Saver HDHP	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Total Monthly Premium	$670.23	$1,340.51	$1,239.85	$1,910.07
Employee Deduction (Semi-Monthly)	$107.24	$214.48	$198.38	$305.61

Telemedicine/Virtual Visits - BlueCare Telemed Services

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**: Go to www.BlueCareLA.com or download the BlueCare app for Android or iPhone.
- **Step 2:** Create your account with a username and password, which you will use for each BlueCare 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, BlueCare 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, BlueCare providers are unable to provide medical certifications for disability claims, leaves of absence or work-related injuries.

Dental Insurance

Carrier: Ameritas

- You will pay less out-of-pocket when you choose an in-network provider.
- Locate an in-network provider at www.ameritas.com
- Out-of-network providers can balance bill (bill you for the difference between the provider's charge and the allowed amount).
- Please refer to the official plan documents for additional information on coverage and exclusions.

Covered Benefits	In-Network
Calendar Year Deductible	$50 per person, $150 per family
Annual Plan Benefit Maximum	$2,000 per covered member
Preventive Care - Type 1 Routine exam, bitewing x-rays, full mouth/panoramic x-rays, periapical x-rays, cleanings, fluoride (children 18 and under), sealants (age 18 and under), space maintainers	100%
Basic Services - Type 2 Restorative amalgams/composites, endodontics (surgical/non-surgical), periodontics (surgical/non-surgical), denture repair, simple/complex extractions, anesthesia	80%
Major Services Onlays, crowns, crown repair, implants, prosthodontics (fixed bridge, removable complete/partial dentures)	60%
Orthodontic Services Available to dependent child(ren) to age 19	50%
Orthodontic Lifetime Maximum	$2,000

Semi-Monthly Dental Deduction

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$25.93	$51.37	$57.58	$81.93

Vision Insurance

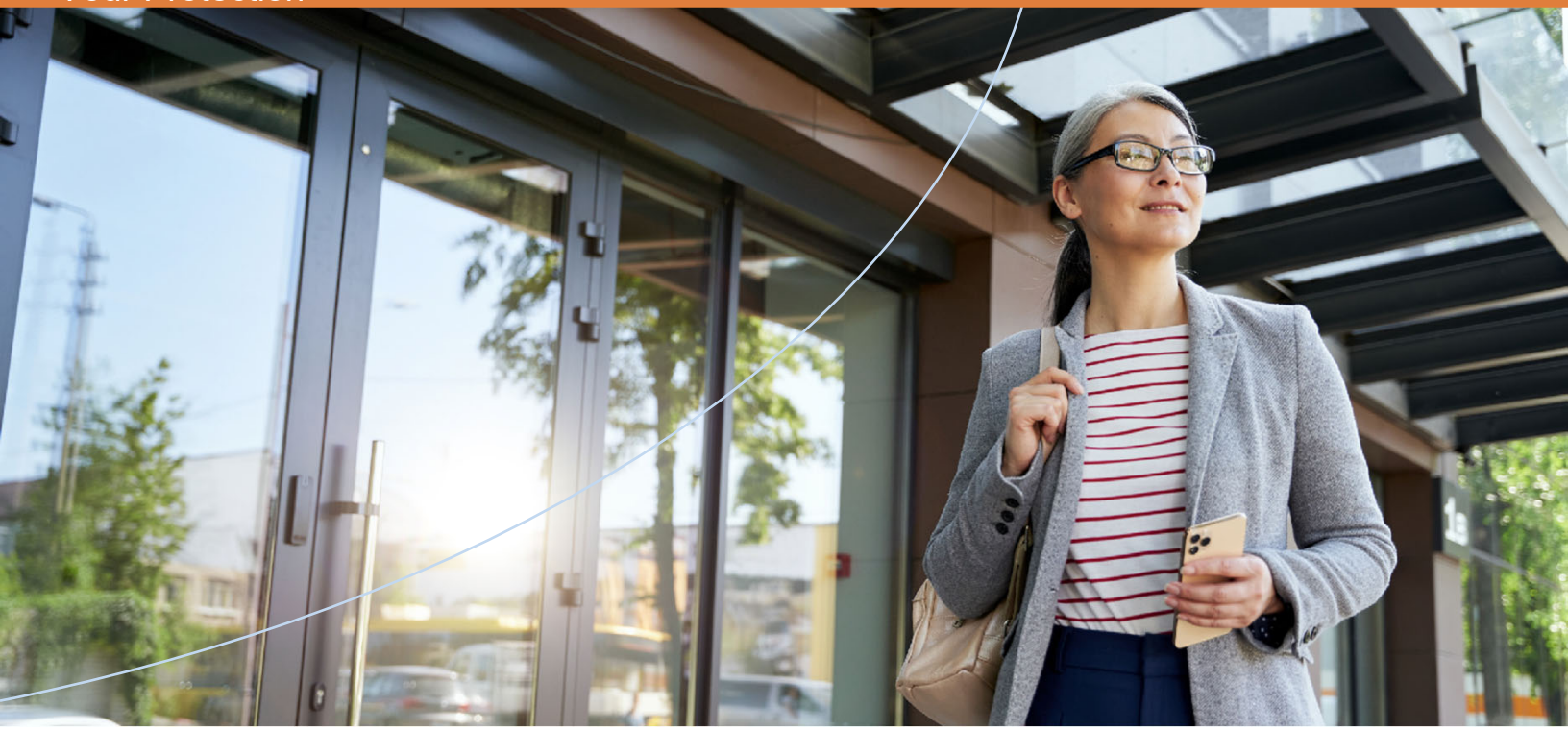
Carrier: Ameritas

- You will pay less out-of-pocket when you choose an in-network provider.
- Locate an in-network provider at www.ameritas.com
- You must submit a claim for out-of-network expenses.
- Please refer to the official plan documents for additional information on coverage and exclusions.

Covered Benefits	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)	$120 allowance Costco and Walmart allowance will be wholesale equivalent	$70 allowance
Contact Lenses (every 12 months in lieu of standard plastic lenses) **Fit / Follow-Up Exam** **Elective** **Medically Necessary**	 $60 allowance $120 allowance Plan pays 100% after $25 copay	 No benefit $105 allowance $210 allowance

Semi-Monthly Vision Deduction

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$3.18	$6.32	$5.85	$9.00



Group Life Insurance

Carrier: Equitable Life

Life and Accidental Death & Dismemberment (AD&D)

Basic Life and AD&D Insurance is automatically provided to all benefits-eligible employees at no cost. If you die as a result of an accident, your beneficiary would receive both the life and the AD&D benefit.

- Life Insurance Amount: 1.5 x annual salary ($130,000 max)
- AD&D Amount: Equal to life insurance amount
- Please refer to the official plan documents for additional information on coverage and exclusions.

Voluntary Life Insurance

Carrier: Equitable Life

ONE TIME TRUE OPEN ENROLLMENT – NO EOI REQUIRED UP TO GUARANTEE ISSUE MAXIMUMS

What is Voluntary Life Insurance?

Voluntary Life Insurance is offered through an employer but is paid by employees.

Why purchase voluntary life insurance?

- This type of life insurance has limited underwriting required. This allows for people with health conditions or lifestyles that might otherwise disqualify them to qualify for life insurance.
- The group rates are lower than what you could purchase on your own.
- You may purchase a policy for your spouse and children IF you elect coverage for yourself.
- Please refer to the official plan documents for additional information on coverage and exclusions.

REMINDER

Review your beneficiary designations

Voluntary Life Insurance *Cont.*

Carrier: Equitable Life

Employee

- **Benefit Amount:** $10,000 increments up to 5x your annual salary not to exceed $500,000
- **Guarantee Issue Amount:** $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

Spouse

- **Benefit Amount:** $5,000 increments up to maximum of $250,000
- **Guarantee Issue Amount:** $50,000*
- **AD&D Amount:** 100% of supplemental life benefit amount
- **Age Reduction Schedule:** 35% at age 70, 50% at age 75, and 70% at age 80
- ***Spouse cost is based on spouse's age***

Child(ren) to Age 26

- **Benefit Amount:** $10,000

Notes:

- Rates are age-banded; cost increases with age
- Employee must be enrolled in Supplemental Life Coverage for dependents to enroll in coverage
- Supplemental Life Coverage is portable upon Retirement
- **Evidence of Insurability: For 2024 only, Equitable Life is allowing eligible employees to apply for New or Increased coverage, up to Guarantee Issue without requiring Evidence of Insurability (EOI).**

Employee / Spouse Monthly Premium

Age	Rate per $1000
0-29	$0.10
30-34	$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
75-79	$4.49
80-84	$7.16

Child(ren) Monthly Premium

Rate per $1000
$2.00

Disability Insurance

Carrier: Equitable New Carrier!

ONE TIME TRUE OPEN ENROLLMENT – NO EOI REQUIRED

Short-Term Disability Insurance

Short-Term Disability (STD) Insurance is designed to help you meet your financial needs if you become unable to work due to a nonwork related illness or injury. **Short Term Disability Insurance is a voluntary plan; employees are responsible for 100% of the cost.** Premiums are calculated as a percentage of your annual base salary. Benefits may be offset due to other benefits such as paid sick leave, workers' compensation, etc.

- **Benefit Amount:** 60% of base weekly salary up to $2,500 per week
- **Elimination Period:** 30 Days
- **Benefit Duration:** Up to 22 weeks
- **Pre-Existing Condition Waiting Period:** The pre-existing condition is 3/12, which means 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.
- **Evidence of Insurability: For 2024 only, Equitable Life is allowing eligible employees to apply for New or Increased coverage, up to Guarantee Issue without requiring Evidence of Insurability (EOI).**
- Please refer to the official plan documents for additional information on coverage and exclusions.

STD Rates

Monthly Rates per $10 of Monthly Benefit
$0.330

Disability Insurance

Carrier: Equitable New Carrier!

ONE TIME TRUE OPEN ENROLLMENT – NO EOI REQUIRED

Long-Term Disability Insurance

Long-Term Disability (LTD) Insurance is designed to help you meet your financial needs during longer disability periods. **Long Term Disability Insurance is a voluntary plan; employees are responsible for 100% of the cost.** Premiums are calculated as a percentage of your annual base salary. Benefits may be offset due to other benefits such as paid sick leave, workers' compensation, etc.

- **Benefit Amount:** 60% of base monthly salary up to $6,000 per month
- **Elimination Period: 180** Days
- **Benefit Duration:** Until Social Security Normal Retirement Age
- **Recurrent Disability:** 6 months
- **Pre-Existing Condition Waiting Period:** The pre-existing condition is 6/12, which means any condition that you receive medical attention for in the 6 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- **Evidence of Insurability: For 2024 only, Equitable Life is allowing eligible employees to apply for New or Increased coverage, up to Guarantee Issue without requiring Evidence of Insurability (EOI).**
- Please refer to the official plan documents for additional information on coverage and exclusions.

LTD Rates

Age	Monthly Rate per $100 of Monthly Benefit
<25	$0.082
25-29	$0.160
30-34	$0.250
35-39	$0.353
40-44	$0.510
45-49	$0.658
50-54	$1.010
55-59	$1.267
60-64	$1.330
65+	$1.397

Voluntary Critical Illness Insurance

New Benefit!

Carrier: Unum

How does it work?

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.

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

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
- Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

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 as you 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.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other

What's Covered

Critical Illness

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Sudden cardiac arrest
- Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement

Cancer Conditions

- Invasive cancer – all breast cancer is considered invasive
- Non-invasive Cancer (25%)
- Skin Cancer

Progressive Diseases

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental Conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D Occupational PTSD

Paid at 25%

- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Please refer to the official plan documents for additional information on coverage and exclusions.

Voluntary Critical Illness Insurance

New Benefit!

Carrier: Unum

Employee Coverage: $10,000
Spouse Coverage: $10,000
Be Well Benefit: $50

Age	Employee	Spouse
under 25	$3.40	$3.40
25 - 29	$4.30	$4.30
30 - 34	$5.10	$5.10
35 - 39	$6.50	$6.50
40 - 44	$8.30	$8.30
45 - 49	$10.70	$10.70
50 - 54	$13.40	$13.40
55 - 59	$17.80	$17.80
60 - 64	$27.80	$27.80
65 - 69	$37.10	$37.10
70 - 74	$50.50	$50.50
75 - 79	$71.30	$71.30
80 - 84	$99.30	$99.30
85+	$148.70	$148.70

Employee Coverage: $20,000
Spouse Coverage: $20,000
Be Well Benefit: $50

Age	Employee	Spouse
under 25	$6.80	$6.80
25 - 29	$8.60	$8.60
30 - 34	$10.20	$10.20
35 - 39	$13.00	$13.00
40 - 44	$16.60	$16.60
45 - 49	$21.40	$21.40
50 - 54	$26.80	$26.80
55 - 59	$35.60	$35.60
60 - 64	$55.60	$55.60
65 - 69	$74.20	$74.20
70 - 74	$101.00	$101.00
75 - 79	$142.60	$142.60
80 - 84	$198.60	$198.60
85+	$297.40	$297.40

Employee Coverage: $30,000
Spouse Coverage: $30,000
Be Well Benefit: $50

Age	Employee	Spouse
under 25	$10.20	$10.20
25 - 29	$12.90	$12.90
30 - 34	$15.30	$15.30
35 - 39	$19.50	$19.50
40 - 44	$24.90	$24.90
45 - 49	$32.10	$32.10
50 - 54	$40.20	$40.20
55 - 59	$53.40	$53.40
60 - 64	$83.40	$83.40
65 - 69	$111.30	$111.30
70 - 74	$151.50	$151.50
75 - 79	$213.90	$213.90
80 - 84	$297.90	$297.90
85+	$446.10	$446.10

Retiree Benefits

The Zachary Community School District shall contract with a health 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.

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.

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 following reduction schedule:

Life Insurance Benefits and Accidental Death and Dismemberment Benefits for any insured retiree will automatically reduce on the policy anniversary date coinciding with or next following attainment of the ages shown below:

- To 65% - Age 70, but less than 75
- To 50% - Age 75, but less than 80
- To 30% - Age 80 and over

Disability coverage will end when you retire, however you will be able to continue Voluntary Life, Cancer and Long-Term Care coverage. Instructions, Forms, and Rates are included in the Retiree Packet you will receive upon notification of your retirement.

Medical Vesting Schedule

Employees who are hired and enrolled in the group health plan on or after January 1, 2007 will be vested for health insurance benefits as follows.

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%

Employees, and qualified dependents of employees, who were employed by ZCSB prior to January 1, 2007 but not enrolled in the ZCSB group health plan prior to January 1, 2007, will be required to follow the same vesting schedule as employees hired on or after January 1, 2007.

Dependents of Employees Hired on or After January 1, 2007

Dependents of employees who are enrolled on or after January 1, 2007 will have their health insurance benefit vested as follows.

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%

Alternative Coverage

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 ZCSB.

Premium Payment

Payment of the retired employee's portion of the health premium (for all ZCSD employees) must be made in one of following methods:

Method 1 - Bank Draft
Method 2 - Appropriate Retirement Payroll Reduction (when available)
Method 3 - Direct Billing

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 unless you request to opt out.

Blue Cross Blue Shield of Louisiana Medicare - Blue Advantage PPO Plan		
Medical Coverage	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Out of Pocket Maximum *(Does not include Prescription Drugs)*	$1,000 Combined In-Network & Out-of-Network	
Preventive Care	$0 copay	$0 copay
Doctor Visits		
Primary Care Provider Visit	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay
Urgent Care	$0 copay	$0 copay
Diagnostic Services/Labs/Imaging	$0 copay	$0 copay
Hospital Coverage		
Inpatient Hospital	$0 copay	$0 copay
Outpatient Hospital	$0 copay	$0 copay
Ambulatory Surgical Center	$0 copay	$0 copay
Ambulance Services		
Ground Ambulance	$0 copay	$0 copay
Air Ambulance	$0 copay	$0 copay
Emergency Care	$50 copay, waived it admitted within 72 hours	
Mental Health Services	$0 copay	$0 copay
Physical Therapy	$0 copay	$0 copay

	Preferred Retail & Mail Order			Standard Retail & Mail Order		
Prescription Drugs	**1-Month Supply**	**2-Month Supply**	**3-Month Supply**	**1-Month Supply**	**2-Month Supply**	**3-Month Supply**
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	$10 copay	$20 copay	$30 copay
Tier 2 Generics	$12 copay	$24 copay	$0 copay	$18 copay	$36 copay	$54 copay
Tier 3 Preferred Brand	$45 copay	$90 copay	$135 copay	$47 copay	$94 copay	$141 copay
Tier 4 Non-Preferred	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 Specialty	$100 copay	Not Offered	Not Offered	$100 copay	Not Offered	Not Offered

Medicare Advantage

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

Vision Care	In-Network	Out-of-Network
Exam	$0 copay	$0 copay
Diabetic Eye Exam	$0 copay	$0 copay
Eyeglasses or contact lenses 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 coverage amount loaded to your Blue Advantage Flex Card 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 *$1,100 maximum benefit coverage amount loaded to your Blue Advantage Flex Card for both ears combined every year.	$0 copay

*The $300 vision allowance and $1,100 hearing allowance will be loaded on your Blue Advantage Flex Card. In addition, $400 per year ($100 per quarter) will be loaded on your Flex Card to use for over-the-counter (OTC) health-related products ($100 allowance per quarter must be used before the end of the quarter in which it was issued or you lose it!.

Resources and Contacts

Enrollment Instructions

All employees who want coverage under the ZCSD Benefits Program **must make an election in the electronic enrollment system, Employee Navigator**. You will receive an email from Employee Navigator to register as a New User or to logon as a Returning User.

Unum is providing access to a call center with staff available for Q&A, plus to assist with enrolling in Employee Navigator. Use the QR code here to schedule a time for a representative to call you OR you can call the Enrollment Call Center directly at 877-700-8136.

Step 1: Scan the QR code to the right, or go to the following link sign in or create a new account as an employee:

https://www.EmployeeNavigator.com/Benefits/Account/Login

New Users: You will click "Register as a New User"

Note: It is recommended that you use an email address for your username.

Step 2: If you created a new account, you will be asked for personal identifying data as well as the following Company Identifier: **ZACHARY**

Step 3: Wright down the Username and Password you created for future reference.

Step 4: You are ready to make your benefit elections!

Please select the **"Start Benefits"** button. The system will you through the process when you select **"Save & Continue"** on every screen.

Note: IF you are covering a spouse and/or child, please have their full name, DOB and SSN available.

Important Contacts

Benefit	Carrier	Phone	Website/Email
Medical Insurance	Blue Cross Blue Shield of Louisiana	800-599-2583	www.bcbsla.com
Telemedicine/Virtual Care	Blue Cross Blue Shield of Louisiana		www.BlueCareLA.com
Dental Insurance	Ameritas	800-659-2223	www.ameritas.com
Vision Insurance	Ameritas	800-659-2223	www.ameritas.com
Life and AD&D Insurance	Equitable Life	866-274-9887	www.equitable.com
Voluntary Life Insurance	Equitable Life	866-274-9887	www.equitable.com
Disability Insurance	Equitable Life	866-274-9887	www.equitable.com
Critical Illness Insurance	Unum	800-370-5856	www.unum.com
Zachary Community School District	Yolanda Williams	225-658-4969	yolanda.williams@zacharyschools.org
Cadence Insurance	Account Support	225-336-3274	ZacharySchools@CadenceInsurance.com

Unum is providing access to a call center with staff available for Q&A, plus to assist with enrolling in Employee Navigator. Use the QR code here to schedule a time for a representative to call you OR you can call the Enrollment Call Center directly at 877-700-8136.

Glossary

Beneficiary: The person or persons you name to receive benefits in the event of your death. You can change your beneficiary designations at any time.

Primary Beneficiary: The entire death benefit will be paid in equal shares to the primary beneficiary or beneficiaries who survive you.

Contingent Beneficiary: If no primary beneficiary survives you, the entire death benefit will be paid to the contingent beneficiaries. A contingent beneficiary will only receive a benefit if ALL primary beneficiaries predecease the participant.

Coinsurance: The percentage of a covered expense that you must pay after you meet your deductible, but before you reach the annual out-of-pocket maximum. The remaining percentage is paid by the health plan.

Copay: The per-service fee you pay each time you use a telehealth provider through Doctor on Demand or emergency room facility (fee waived if admitted).

Deductible: The amount you must pay each year before the plan begins to pay benefits.

Employee Contribution: The per pay period amount you pay for your insurance coverage.

Explanation of Benefits (EOB) / Personal Health Statement (PHS): A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Evidence of Insurability (EOI): Proof of good health that is required to purchase certain types and/or levels of insurance.

Health Care Cost Transparency: Also known as Market Transparency or Medical Transparency. Health care provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective health care products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

High Deductible Health Plan (HDHP): A medical plan that meets requirements set by the IRS for a minimum deductible amount and a maximum out-of-pocket limit for in-network services.

In-Network: In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network: Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate and your cost sharing (deductibles and coinsurance) will increase.

Out-of-Network Providers: Providers (e.g., doctors, hospitals) that are not part of your plan's network of providers.

Out-of-Pocket Maximum: The limit the medical plan puts on the amount of money you have to pay each year out of your pocket for eligible medical expenses. Once you reach the limit, the plan will pay 100% of your eligible expenses for the rest of the year (in-network only). Amounts you pay for prescription drugs, deductibles and coinsurance apply toward your in-network out-of pocket maximum. You may be subject to balance billing by out-of-network providers even after the out-of-network out-of-pocket maximum is met.

COMPLIANCE DISCLOSURE

PLEASE NOTE: The attached disclosures must be or should be provided to you at open enrollment. However, your employer/plan sponsor will likely have additional disclosure obligations throughout the calendar/plan year. Those disclosures are not included in this booklet. While Cadence Insurance may assist your employer in providing the required disclosures, it is ultimately your employer's responsibility to provide them to you. Please contact your employer if you have questions or need additional information.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact: **zacharyschools@cadenceinsurance.com, Zachary Community School District, 3755 Church Street, Zachary, LA 70791, P: 225-336-3274.**

NEWBORNS' ACT DISCLOSURE

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

Under the law, if your plan provides benefits for obstetrical services, your benefits will include coverage for postpartum services. Coverage will include benefits of inpatient care and home visit(s), which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors and copayments that are no less favorable than for physical illness generally.

PATIENT PROTECTION NOTICE

Blue Cross Blue Shield of Louisiana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan administrator listed below.

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

You do not need prior authorization from **Blue Cross Blue Shield of Louisiana** 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 our 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 **Blue Cross Blue Shield of Louisiana.**

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) *Continued*

ALABAMA – MEDICAID
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - MEDICAID
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - MEDICAID
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991
State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA - MEDICAID
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – MEDICAID
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website:
https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS - MEDICAID
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA - MEDICAID
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - MEDICAID
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA - MEDICAID
Website:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI - MEDICAID
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA- MEDICAID
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - MEDICAID
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - MEDICAID
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - MEDICAID
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - MEDICAID
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA - MEDICAID
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON - MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthca re.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA - MEDICAID
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - MEDICAID
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT - MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - MEDICAID
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - MEDICAID
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) *Continued*

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

THE WOMEN'S HEALTH AND CANCER RIGHTS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance may apply. If you would like more information on WHCRA benefits, call your plan administrator: **zacharyschools@cadenceinsurance.com, Zachary Community School District, 3755 Church Street, Zachary, LA 70791, P: 225-336-3274.**

WOMEN'S HEALTH AND CANCER RIGHTS ENROLLMENT NOTICE

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

Call your plan administrator at: **225-336-3274** or more information.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Name of Health Plan: Zachary Community School District

Why is the Plan providing me with this Privacy Notice?

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules"). The HIPAA Privacy rules are federal laws that seek to ensure the privacy and confidentiality of your health information. The HIPAA Privacy Rules require the Plan to take certain actions to protect the privacy of your health information. This Notice has been prepared to advise you of the uses and disclosures of your Protected Health Information (as defined below) that may be made by the Plan and to advise you of your rights and the Plan's legal duties relating to the privacy of your Protected Health Information.

What is Protected Health Information?

Protected Health Information generally is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

For example, the information included in an explanation of benefits ("EOB") from the Plan is Protected Health Information. In addition, Protected Health Information includes genetic information which includes information about your genetic tests or the genetic tests of your family members or the manifestation of a disease in one of your family members. For example, the fact that your spouse is diagnosed with Type II diabetes is genetic information.

Will the Plan have access to my Protected Health Information?

Yes. As an individual enrolled in the Plan, you should be aware that the Plan may have access to your Protected Health Information from time to time. The Plan may receive your Protected Health Information in a variety of ways. An example of how the Plan may receive this information is when your healthcare provider, such as your doctor or your hospital, submits bills for services rendered to you to be paid by the Plan.

When may the Plan use or disclose my Protected Health Information?

The law permits the Plan to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations". When the Plan makes uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes, the Plan is not required to notify you or obtain your Authorization (discussed further below).

Treatment: Treatment means the provision, coordination, or management of healthcare and related services by health care providers, including the coordination or management of health care by a health care provider with a third party (such as an insurer of the Plan), consultation between providers with respect to a patient, and the referral of a patient for health care from one provider to another. The Plan itself does not engage directly in "treatment" under the HIPAA Privacy Rules. However, the Plan may interact with a health care provider in treatment transactions.

Payment: Payment means activities undertaken by the Plan to determine eligibility for benefits or fulfill its responsibility for coverage and provision of benefits under the Plan. Examples of when the Plan might use or disclose Protected Health Information for payment purposes include disclosures to facilitate the payment of claims made on the Plan by health care providers, the Plan's activities to obtain or provide reimbursement for the provision of health care, or the Plan's activities in obtaining premiums. When the Plan discloses information for payment purposes, the Plan will attempt only to disclose that Protected Health Information which is minimally necessary to ensure proper and timely payment of claims.

Health Care Operations: The term "health care operations" means those other functions and activities that the Plan performs in connection with providing health care benefits. Examples of what constitute health care operations during which the Plan might use or disclose your Protected Health Information include activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, business planning and development relating to the Plan, and compliance with the HIPAA Privacy Rules. Another example would include the Plan's use or disclosure of Protected Health Information to better manage its operations, such as when the Plan discloses information with a vendor or consultant (commonly referred to as a "Business Associate") to ensure proper accounting and record-keeping relating to the Plan's provision of health care benefits. Under contractual agreements with the Plan, Business Associates can receive, create, maintain, use, and disclose your Protected Health Information, without your consent, but only to assist the Plan with its payment, operations, and other limited purposes.

May the Plan use or disclose my Protected Health Information for other purposes?

Yes. For uses or disclosures of Protected Health Information that are not made for treatment, payment, or health care operations purposes and for which no exception regarding Authorization applies, the law requires the Plan to obtain your Authorization. An Authorization is your approval for the Plan's disclosure of your Protected Health Information to a particular person or entity for a particular purpose. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes. You may revoke an Authorization at any time, but a revocation is not effective if the Plan has already reasonably relied on your Authorization to make a particular use or disclosure. Examples of when an Authorization would be required include when the uses or disclosures are made to your employer for disability, fitness for duty or drug testing purposes. Additionally, if you request that the Plan use or disclose your Protected Health Information, the Plan may require that you sign an Authorization that permits the Plan to honor your request.

When might the Plan make a use or disclosure of my Protected Health Information without my Authorization?

As discussed above, the Plan is not required to obtain your Authorization to use or disclose your Protected Health Information for treatment, payment or health care operations purposes. Additionally, there are some limited exceptions in which the law allows the Plan to use or disclose your Protected Health Information for purposes other than treatment, payment, or health care operations without your Authorization. Most of these uses or disclosures are

HIPAA PRIVACY NOTICE *Continued*

the types of uses or disclosures of Protected Health Information that may be made without your Authorization and without giving you the opportunity to object include those made: to avert communicable or spreading diseases; for public health activities; for federal intelligence, counter-intelligence and national security purposes; to properly assist law enforcement to carry out their duties; when a judge or administrative tribunal orders the release of such Protected Health Information; for cadaveric organ, eye and tissue donations (where appropriate); to help apprehend criminals; to assist armed forces personnel and operations; for military service, veterans affairs separation/discharge matters; for coroner/medical examiner purposes; for health oversight purposes (such as when the government requests certain information from the Plan to determine its compliance with applicable laws); to assist victims of abuse, neglect or domestic violence; to address work-related illness/workplace injuries and for workers' compensation purposes; to carry out clinical research that involves treatment where the proper body has determined the importance for doing so; for FDA-related purposes; for certain health and safety purposes; for funeral/funeral director purposes; to help determine veterans eligibility status; to protect Presidential and other high-ranking officials; and for reporting to correctional institutions/law enforcement officials acting in a custodian capacity.

There are also several types of uses or disclosures of Protected Health Information that the Plan may make without your Authorization as long as, whenever possible, you are given an opportunity to agree or object before the Plan makes the use or disclosure. These exceptions are very limited and generally involve the release of a limited amount of Protected Health Information to aid your family members, close personal friends, or disaster relief personnel in locating you in the event of an emergency or in case of your incapacity.

Will the Plan disclose my Protected Health Information to my employer?

The Plan has the right to disclose your Protected Health Information to the Plan Sponsor, which is usually your employer, subject to certain limitations. The Plan may generally disclose to the Plan Sponsor information regarding whether you are enrolled in the Plan and "summary health information," which means information that summarizes the claims history and experiences of the individuals enrolled in the plan without specifically identifying you or other plan participants. The Plan may disclose this information without your Authorization, and the Plan Sponsor may only use the information for its activities relating to its sponsorship of the Plan. For example, the Plan Sponsor may use this information to seek bids from health insurers or to analyze its health plan expenses. If the Plan Sponsor needs more than "summary health information" or enrollment information to carry out its responsibilities, then documents that govern the Plan will determine the extent to which Protected Health Information may be used or disclosed, except that in no case may the Plan Sponsor use or disclose your Protected Health Information for employment-related decisions or for any other purposes other than as permitted by the Plan documents or by law. Additionally, Plan Sponsors that receive Protected Health Information from the Plan must make certain certifications to the Plan regarding the uses and disclosures of the information and must ensure that any agents or subcontractors of the Plan Sponsor agree to the same restrictions and conditions that apply to the Plan Sponsor.

Will the Plan use or disclose my Protected Health Information for marketing, fundraising or other similar purposes?

While the Plan does not anticipate using or disclosing your Protected Health Information for marketing, fundraising or other similar purposes, under the HIPAA Privacy Rules, the Plan may only make such uses or disclosures with your Authorization, unless the Plan communicates with you face-to-face or provides you with some promotional gift of nominal value, in which case your Authorization would not be required.

Is the Plan Subject to Other Restrictions Regarding the Use and Disclosure of my Protected Health Information?

The Plan will not:

(1) use your genetic information for underwriting purposes, which includes determining whether you are eligible for benefits; or
(2) directly or indirectly receive payment in exchange for your Protected Health Information unless the Plan obtains a valid authorization from you.

Do I have the right to request additional restrictions on the uses or disclosures of my Protected Health Information?

Yes. You have the right to request additional restrictions relating to the Plan's use or disclosure of your Protected Health Information beyond those otherwise required under the HIPAA Privacy Rules. You also have the right to limit disclosures to family members or friends who are involved in your care or payment for your care. For example, you could ask that the Plan not use or disclose information about a surgery that you had. Although the Plan is not legally required to grant these requests, it is your right to make such a request. If the Plan agrees to the restriction, it can stop complying with the restriction after providing notice to you. For additional information or to obtain the proper form for making such a request, please contact the Plan's Privacy Officer.

May I request that certain communications of my Protected Health Information be made to me at alternate locations?

Yes. The Plan may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that the Plan's communications to you by the usual means will endanger you or your health care and you would like the Plan to make its communications that involve Protected Health Information to you at an alternate location, you may contact the Plan's Privacy Officer to obtain the appropriate request form. The Plan will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

Do I have the right to obtain access to my Protected Health Information?

Generally yes. You have the right to request and obtain access to your Protected Health Information maintained by the Plan unless an exception applies. The Plan may deny you access to your Protected Health Information if the information is not required to be accessible under the HIPAA Privacy Rules or other applicable law. For example, you do not have a right to access information compiled by the Plan in anticipation of or for use in a civil, criminal or administrative proceeding.

If the information you request is maintained electronically, and you request an electronic copy, the Plan will provide a copy in the electronic form and format you request, provided the information may be readily produced in that manner. If not, the Plan will work with you to come to an agreement on form and format. If you and the Plan cannot agree on an electronic form and format, the Plan will provide you with a paper copy.

The Plan may charge you a reasonable, cost-based fee for copying (including the cost of supplies and labor) any Protected Health Information required to be copied to adequately respond to your access request, as well as any postage costs and costs associated with preparing an explanation or summary of the Protected Health Information necessary to adequately respond to your access request (unless otherwise precluded by applicable State or other law). If you would like to request access to your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

HIPAA PRIVACY NOTICE *Continued*

Do I have the right to request an amendment to my Protected Health Information?

Yes. You have the right to request that the Plan amend your Protected Health Information. The Plan reserves the right to deny or partially deny requests for amendments that are not required to be granted under the HIPAA Privacy Rules. For example, the Plan may deny a request for amendment when the Protected Health Information at issue is accurate and complete. If you would like to request an amendment of your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

Do I have the right to an accounting of disclosures of my Protected Health Information made by the Plan?

Yes. You have the right to request and obtain a proper accounting of disclosures the Plan has made of your Protected Health Information. The Plan is not required to account for all uses and disclosures of Protected Health Information that the Plan makes. For example, the Plan is not required to provide an accounting for disclosures made for treatment, payment, or health care operations purposes or for disclosures made with your Authorization. Additionally, the Plan reserves the right to limit its accountings to disclosures made after the compliance date of the HIPAA Privacy Rules.

The Plan will provide you with your first accounting at no charge to you. If you request any additional accountings within a 12-month period, the Plan may charge you a reasonable, cost-based fee. At the time that you request a subsequent accounting, the Plan will provide you with information regarding the fees, and you will have the opportunity to withdraw or modify your request if you wish to do so. If you would like to request an accounting of your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

Do I have the right to receive notice if the privacy or security of my Protected Health Information is compromised?

Yes. In certain circumstances, you have the right to receive notice from the Plan if the privacy or security of your Protected Health Information is compromised. The notice will describe what occurred, the date of the occurrence (or if later, the date on which the Plan learned of the occurrence), the type of information involved, actions you should take to protect your information, and actions the Plan is taking to mitigate the harm and reduce the likelihood of recurrence.

If I have an objection to the way my Protected Health Information is being handled, may I file a complaint?

Yes. The Plan has procedures in place for receiving and resolving complaints. If you believe that the Plan has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules, you may file a complaint by contacting the Plan's Privacy Officer. You may send a letter outlining your complaint to the Privacy Officer or you may call the Privacy Officer and request a complaint form. The Plan requests that you attempt to resolve your complaint with the Plan via these complaint procedures since the Plan is in the best position to respond to your complaint. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights ("OCR") at the United States Department of Health and Human Services ("HHS"). You may contact the HHS OCR at: Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, Voice Hotline Number (800) 368-1019, Internet Address www.hhs.gov/ocr.

It is against the policies and procedures of the Plan to retaliate against any person who has filed a privacy complaint, either with us or with HHS OCR. Should you believe that you are being retaliated against in any way upon your filing a complaint with us or the HHS OCR, please immediately contact the Plan's Privacy Officer, so that the Plan may properly address the issue.

May the Plan amend this Notice?

Yes. The Plan is required to abide by the Notice that is currently in effect; however, the Plan reserves the right to change the terms of this Notice at any time and to make the new Notice effective for all Protected Health Information maintained by the Plan. If this Notice is amended, you will be provided with a copy of the new Notice through regular mail, electronic mail, posting at work site, posting on Intranet sites, or by some other reliable method intended to reach all Plan participants.

May I obtain a paper copy of this Notice?

Yes. If you received this Notice via the Internet or electronic mail, you have the right to request and receive a paper copy of this Notice. If you would like to receive a paper copy of this Notice, please contact the Plan's Privacy Officer.

What if I have additional questions that are not answered in this Notice?

If you have any questions, concern or issues relating to the privacy of your Protected Health Information that is not covered in this Notice, please contact the Plan's Privacy Officer.

How do I contact the Plan's Privacy Officer?

You may contact the Plan's Privacy Officer by calling **zacharyschools@cadenceinsurance.com** at **225-336-3274** or writing to:

Zachary Community School District
3755 Church Street
Zachary, LA 70791

What is the effective date of this Notice?

This Privacy Notice is effective as of **September 1, 2024**

About Us

Cadence Insurance, A Gallagher Company, delivers the highest standard in brokerage services nationally and globally to individuals, small companies, and organizations with more than 10,000 employees. We are an industry leader in commercial insurance, surety, employee benefits, and private client brokerage services that invests in technology and human capital to expand service offerings and create a competitive advantage for clients.

Connect With Us

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