WICHITA STATE UNIVERSITY

INTERCOLLEGIATE ATHLETIC ASSOCIATION, INC.

Summary of Employee Benefit Plans

2024

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The benefits shown in this guide are only a summary of the benefits and do not include all the plan's limitations, exclusions, preauthorization requirements and conditions of coverage. Not all services are covered by your health plan. Refer to your plan's summary plan description, insurance company's master policy or certificate of insurance for a complete description of covered benefits. If you have questions about contracting providers or your benefits, contact your claims payer or insurance company for more information.

Each benefit plan may be amended or terminated at the sole discretion of Wichita State University Intercollegiate Athletic Association, Inc (ICAA). Furthermore, nothing in this Summary of Employee Benefit Plans is intended to guarantee employment of any employee with Wichita State University Intercollegiate Athletic Association, Inc (ICAA).

WICHITA STATE UNIVERSITY
Department of InterCollegiate Athletics * 1845 Fairmount * Wichita, Kansas 67260-0018

Dear ICAA Staff:

Our employees are one of our most important assets. We recognize the importance of your family's need for financial security, which is why we strive to offer a comprehensive benefits package.

This booklet is designed to give an overview of the various benefits plans that you can participate in. I hope you find it informative in helping to make the important decisions concerning coverage for yourself and your family.

Sincerely,

Kent Hegenauer
Chief Financial Officer/Senior Associate Athletic Director

Important Information

Open Enrollment

Open Enrollment is the one time per year you may start, stop or change who is insured on your insurance plans. Any requests after Open Enrollment to start, stop or change who is insured must be due to a Qualifying Life Event listed below.

Mid-Year Changes

After your initial eligibility date, you may only change your benefit election and covered dependents within 31 days following a Qualifying Life Event including:

- Birth or adoption of a dependent child;
- Marriage, legal separation, annulment, or divorce;
- Death of spouse and/or dependent;
- Spouse/Dependent's loss of eligibility (see above);
- Termination or commencement of spouse's employment with health care coverage offered or open enrollment;
- Employee or spouse's eligibility for Medicare.

Who is Eligible?

All active, full time employees regularly working at least 30 hours per week are eligible for all benefits the first of the month following 30 days.

As an employee eligible to enroll in the group insurance plans, you may elect to enroll your dependents in some of the benefit plans.

Eligible dependents include:

- Your legal spouse;
- Your dependent child or step child up to age 26 for the medical plan.
- Any child placed with you for adoption or for whom you have legal guardianship;
- Any unmarried, disabled child of any age who resides with you, medically certified as disabled prior to his/her 26th birthday and primarily dependent upon you for support;
- Any eligible child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

Healthcare Reform

Due to Healthcare Reform:

- The individual mandate became effective on 01/01/2014
- For tax year 2024, if you do not have coverage the fee/penalty no longer applies. This is subject to change if different legislation is passed.

Healthcare Reform Exchanges:

- If you are eligible for benefits at WSU ICAA, and buy coverage through a Federal or State Exchange- you and your family will not qualify for a subsidy through the Exchange.
- WSU ICAA offers medical plans that meet the Minimum Essential Benefits guidelines and are deemed Affordable per Health Care Reform guidelines.
- Federal and State Medicaid programs offer low cost or free medical coverage to individuals and families with limited incomes. Your eligibility will depend on your state, income, and family size. For more info visit: www.healthcare.gov.

Medical Insurance Plans

Insured by Blue Cross Blue Shield of Kansas

Plan Year 01/01/24 – 12/31/24 Calendar Deductible 01/01/24 – 12/31/24

	Option 1 - $1,500
Deductible	$1,500 per person $3,000 per family
Coinsurance	20%
Maximum Out-of-Pocket Includes deductibles, copayments, and coinsurance	$6,350 per person $12,700 per family
Primary Care Office Visits **Telehealth Visits**	$35 Copay $35 Copay
Specialist Office Visit	$70 Copay
Routine Vision Exam	$35 Copay - 1st routine eye exam $70 Copay - Subsequent visits
Preventive *(see certificate)*	100% Covered per Health Care Reform
Outpatient Mental Illness & Substance Use Disorders	$35 Copay
Outpatient Lab & Radiology (Includes advanced imaging)	Paid at 100% up to a combined maximum of $300 for each covered person, each benefit period.
Outpatient Surgery	Subject to Deductible & Coinsurance
Inpatient Services	Subject to Deductible & Coinsurance
Emergency Services Emergency Room Urgent Care	 $250 Copay then Deductible & Coinsurance $35 Copay
Ambulance *(ground or air)*	Subject to Deductible & Coinsurance
Lifetime Benefit	Unlimited
Prescription Drugs Generic Preferred Brand Non-Preferred Brand Specialty Non-Preferred Specialty	 $15 Copay $50 Copay $75 Copay $150 Copay 20% up to $250

This is only a brief summary of the benefits. Refer to the BCBS summary of benefits for more detailed information.

Medical Insurance Plans

Insured by Blue Cross Blue Shield of Kansas

Plan Year 01/01/24 – 12/31/24 Calendar Deductible 01/01/24 – 12/31/24

	Option 2 - $5,000 High Deductible Health Plan
Deductible	$5,000 per person $10,000 per family
Coinsurance	0%
Maximum Out-of-Pocket Includes deductibles, copayments, and coinsurance	$6,350 per person $12,700 per family
Primary Care Office Visits **Telehealth Visits**	100% Covered After Deductible 100% Covered After Deductible
Specialist Office Visit	100% Covered After Deductible
Routine Vision Exam	100% Covered After Deductible
Preventive *(see certificate)*	100% Covered per Health Care Reform
Outpatient Mental Illness & Substance Use Disorders	100% Covered After Deductible
Outpatient Lab & Radiology (Includes advanced imaging)	100% Covered After Deductible
Outpatient Surgery	100% Covered After Deductible
Inpatient Services	100% Covered After Deductible
Emergency Services Emergency Room Urgent Care	 100% Covered After Deductible 100% Covered After Deductible
Ambulance *(ground or air)*	100% Covered After Deductible
Lifetime Benefit	Unlimited
Prescription Drugs Generic Preferred Brand Non-Preferred Brand Specialty Non-Preferred Specialty	 $15 Copay After Deductible $50 Copay After Deductible $75 Copay After Deductible $150 Copay After Deductible 20% up to $250 After Deductible

This is only a brief summary of the benefits. Refer to the BCBS summary of benefits for more detailed information.

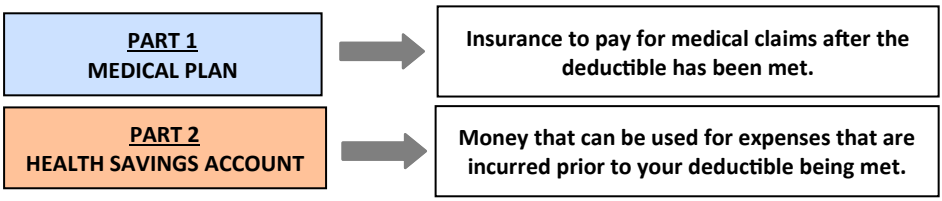
Health Savings Account Information

If you enroll in the Option 2 - $5,000 High Deductible Health Plan (HDHP) you will be able to open a Health Savings Account (HSA). You can open a HSA account at any bank or credit union which offers this service. You are responsible for opening your own HSA and making contributions. With an HSA, you can deposit money into your account and use the HSA money to pay for eligible medical expenses. When you do your taxes at the end of the year, it will be an "above the line" deduction, therefore your taxable income is reduced by the amount you contributed to your HSA.

Your HSA is completely portable. Whether you change jobs, change medical coverage, change marital status, become unemployed or move to another state, you keep your HSA.

****Important****

You should open your HSA prior to the effective date of your High Deductible Health Plan (HDHP). Medical costs incurred after your HDHP is effective, but before your HSA is established, can not be paid with money deposited in your HSA.



HSA Advantages:

- You own the account - If you retire or leave employment the account stays with you.
- All contributions and earnings on the account are tax free.
- Balances in the account roll-over from year to year with no aggregate maximum—you do not lose the money.

You can use money in your HSA to pay for eligible expenses including:

- Deductibles
- Copays
- Coinsurance
- Chiropractic Care
- Prescriptions
- Dental Expenses
- Orthodontics
- Long Term Care Services
- Vision Expenses
- Glasses/Contacts
- Ambulance/ER Services
- Breast Pumps & Accessories

OTC Medications: Written prescriptions are not required for Over the Counter (OTC) drugs, including items like Tylenol, Claritin, Tamiflu, etc. when purchased with an FSA or HSA.

Menstrual Care Products: Menstrual care products, including items like tampons, pads, cup, etc. are eligible expenses under an FSA or HSA.

*See IRS publication 502 for a full list of eligible expenses.

Health Savings Account FAQ's

1. **Who can have an HSA?** The individual must be:
   - Covered by a HDHP (only Option #2);
   - not covered under other health insurance;
   - not enrolled in Medicare; and
   - not another person's dependent.
2. **Where can I open an HSA?** Many banks and credit unions offer HSA's.
3. **When do I see the tax savings?** When you do your taxes at the end of the year, it will be an above the line deduction, therefore your taxable income is reduced by the amount you contributed to your HSA.
4. **If I switch jobs, do I lose my money?** No. The money in your HSA is yours. Whatever money you contribute to your HSA is yours, just like if you had a bank savings account. If you do not use all your HSA money during the year, it will roll over to the next year.
5. **How much can I contribute to my HSA account?**
   2024: Individual Coverage - up to $4,150 per year; Family Coverage - up to $8,300 per year
   Age 55+ can contribute an additional $1,000. Limits apply.
7. **What happens if I lose my health insurance?** You may continue to use your HSA money to pay for eligible expenses, even if you do not have a qualifying health insurance plan, but you cannot keep contributing money to your HSA.
8. **Can I use my HSA money to pay for my premiums?** HSA money can pay for health insurance premiums if you are collecting Federal or State unemployment benefits or are paying COBRA premiums.
9. **What if I need medical care in another country?** You can use your HSA money for the same medical expenses anywhere in the world.
10. **Can I withdraw my HSA money if I need to?** Yes, but the withdrawal is taxable and you will pay a 20% penalty for non-qualifying withdrawals.
11. **When I die, do I lose my HSA money?** No. You can name a beneficiary to receive your HSA money.
12. **How much does it cost to set up an HSA?** This depends on the bank or credit union you choose. Most usually have a one-time set up fee, monthly fee, debit card fees, printed check fees, and overdraft fees. Shop around for the lowest fees.
13. **Can my HSA be used for dependents not covered by the health insurance?** Generally, yes. Qualified medical expenses include unreimbursed medical expenses of the account holder, his or her spouse, or dependents, even if they are not insured by a qualified HDHP.
14. **Do I need to keep any records when I use my HSA?** Although some financial institutions track the use of the HSA for you, it is a good idea to keep your own records. It is your responsibility to track the use of your HSA account and you may be required to show proof of your expenditures to the IRS. We recommend you designate a place to store all your receipts so they are available when you need them.
15. **What if I do not use all of the money in my HSA account by the end of the year?** All the money deposited in your HSA, but not spent during the year, rolls over to the next year. HSA's do not have a "use or lose it" provision. You have the option of accumulating money in your HSA to pay for future eligible expenses and never pay taxes on the money.
16. **Will my bank notify me if I have exceeded my allowable contribution amount?** No, it is your sole responsiblity to keep track of the amounts deposited and spent from your account.

***Please Note: By selecting the HDHP and Health Savings Account (HSA) you may not participate in the WSU ICAA Flexible Spending Account (FSA).**

PPO Plan Information

In a Preferred Provider Organization (PPO) health plans, employees and dependents choose their physician, other healthcare providers and dentists from a select list of contracting providers offering quality care along with substantial discounts. By receiving your care from providers who contract with your PPO network, you will receive the highest level of benefits offered by the plan. The list of contracting providers can change. You should verify that the healthcare provider is contracting with the PPO network prior to each service.

Your medical plan uses the Blue Choice PPO Network. If you choose to receive your medical care from a provider who does not contract with the Blue Choice PPO Network, you will be responsible for a higher deductible and coinsurance amounts. In addition, your benefits will be based on an "allowed" amount which is similar to the amount received by a contracting provider. A non-contracting provider can balance bill you the difference between the "billed" and "allowed" amount.

If you receive services from a non-contracting provider, the amount you will pay could be substantially more than if you receive services from a contracting provider.

TO FIND CONTRACTING BCBS PROVIDERS:

1. Go to **www.bcbsks.com**
2. Under "Find a Doctor/Hospital" click on "Doctor/Hospital Search"
3. From the drop down, select "Blue Choice Preferred - Care Blue Networks" and enter you location. Or, if you log into BlueAccess first, the tool will automatically select the appropriate network.
4. Then you can search for a doctor, hospital, or other health care provider.

BCBS Preventive Services

Consumers can receive some preventive services without any cost-sharing, meaning they will not pay deductibles, copays or coinsurance for the preventive services outlined. Preventive services must be provided by an eligible contracting provider as outlined in the member benefit description. **Preventive services are subject to change.** Please visit our website at **www.bcbsks.com** to get the latest information as it becomes available.

2024 BCBS Contract Changes

- **No Surprises Act (effective 1/1/2023)** – Cost sharing for out-of-network emergency services, air ambulance services, or services provided by a non-contracting provider at an in-network facility is set based on state and federal regulations.
- **Pandemic Surveillance Testing (clarification only)** – Associated services with any mass screening type of physical or health examination are excluded. Examples of mass screenings are mobile vans, school testing programs, surveillance testing and testing for purposes of employment.
- **Virta Health** – Delivers a clinically-proven treatment to safely and sustainably reverse type 2 diabetes (T2D) and other chronic metabolic diseases without the use of medications or surgery.

Telemedicine

Telemedicine is an alternative to in-person doctor visits. See a doctor anytime, anywhere. Telemedicine is a fast, convenient way to see a doctor virtually!

Employees with Blue Cross and Blue Shield of Kansas (BCBSKS) coverage can have a live visit on their computer or mobile device with a doctor at a time that works for them.

Benefits:

- Less time away from work
- Convenience
- No exposure to other contagious patients
- Available 24/7/365
- Easy Payment with credit, debit or HSA/FSA card

When to use Telemedicine?

For common conditions including:

- Cold/Flu
- Fever
- Sinus Infection
- Rash
- Pink Eye
- Ear Infection
- Stomach Pain
- Migraine

There are also behavioral health and counseling services, known as teletherapy. Licensed therapists will provide treatment for several conditions, including:

- Attention deficit hyperactivity disorder (ADHD)
- Obsessive-Compulsive Disorder (OCD)
- Trauma/Post-Traumatic Stress Disorder
- Depression
- Stress/Anxiety/Panic Attacks
- Bereavement

Three ways to register:

1. Download the "Amwell" app on any mobile device.
2. Sign-up at bcbsks.com/telemed
3. Call toll-free 844-733-3627

For more information, visit amwell.com/cm or email support@americanwell.com.

BCBS Online:

By registering on BlueAccess, you can find the answers to your health and benefit questions and the information you need in one easy-to-use, convenient location online.

You can do things like:

- Verify benefits, review your claim information, and order a new ID Card
- Access Member Newsletters & Wellness Media Library
- Enroll in "Healthy Options" which is a disease/ wellness management programs. Nurses provide one-on-one support, coaching and education through regular telephone calls.

How to Register in BlueAccess®

1) Once you receive your BCBS ID Card, go to **bcbsks.com/blueaccess** and select "Register for a BlueAccess Account."
2) Have your ID card handy and follow the step-by-step instructions.

Once you have logged in to BlueAccess you will have access to members only services, including exclusive health and wellness resources from Strive, powered by WebMD ONE and Blue365.

2024 Prescription Drug Changes

- **Formulary** – The list of preferred medication is subject to change periodically. Members can obtain the most accurate prescription drug coverage information by selecting the BCBSKS ResultsRx Medication List at bcbsks.com/drugs.
- **MedsYourWay Retail** – MedsYourWay Retail is Prime's approach to delivering the best price available to a member's shopping experience. MedsYourWay provides drug discount card pricing that complements a member's benefit, giving them the lowest price available, whether that be their cost share amount or the discount drug card price. Members can save time and money on covered prescriptions and over-the-counter medications without needing to carry a separate card.

Medication Search

You and your doctor can search for a drug, find out if it's covered, and see if there are alternatives that cost less. It is highly encouraged that you review the formulary list to see if your current medications are covered. If a drug is not on the formulary, it will not be covered by your health plan. This publication lists many of the non-covered drugs along with alternative drugs that are covered. The list is divided into four sections; Non-covered with preferred alternatives, Standard non-covered drugs, Non-covered with over-the-counter alternatives, Non-covered due to high costs.

TAKE THESE STEPS:

1. Go to **www.bcbsks.com**
2. Click "Prescription Drugs", then click "See if your drug is covered"
3. Click on "BCBSKS ResultsRX Medication List"
4. You can search drugs by name or scroll down for the complete drug list.

Note: CVS Pharmacy is an OUT-OF-NETWORK pharmacy.

Rx Mail Order

Home delivery through Express Scripts® Pharmacy is a safe, convenient way to get your long-term medicines delivered right to your door. It may even help you save money. Plus, Express Scripts® Pharmacy offers:

- 24/7 access to a team of knowledgeable pharmacists and support staff
- Free standard delivery and Tamper-proof, unmarked packaging
- Refill reminder notices through your phone or email, whichever you prefer
- Multiple locations across the U.S., for fast processing and dispensing

It's easy to get started:

- Go to esrx.com/BCBSKS.
- Register and create a profile.
- See your active drugs and/or send your refill order.
- Or call 1-833-599-0511

***Express Scripts® Pharmacy mobile app makes it easy to manage your prescriptions!**

EXPRESS SCRIPTS

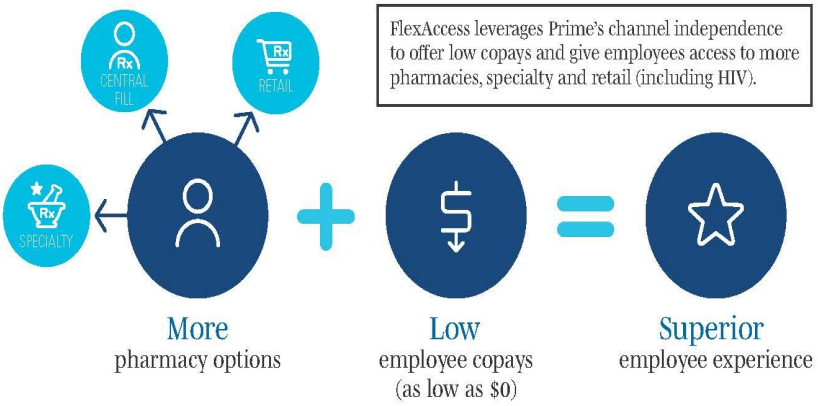
FlexAccess™

Specialty copay solutions

New for 2024

Employee-centric experience. Greater savings opportunities. Expanded pharmacy options.

To reduce persistent cost challenges in the specialty space, having access to a variety of manufacturer copay assistance (also known as coupon) products has been beneficial. However, these existing products provide an inadequate experience for employees. Instead, you may want to consider a solution that provides greater savings opportunities for your group and your employees, more pharmacy options, a seamless enrollment process and a better employee experience overall.



FlexAccess leverages Prime's channel independence to offer low copays and give employees access to more pharmacies, specialty and retail (including HIV).

FlexAccess is Prime's new leading manufacturer copay assistance product. FlexAccess unlocks access to more specialty pharmacies, giving employees an expanded list of pharmacy options to choose from. Another great feature that sets FlexAccess apart from existing coupon products is that it covers HIV medications at retail.

FlexAccess member benefits

- Employee copays almost always $25 or less, which count toward accumulators[1]
- More pharmacy options – specialty and retail (including HIV) – beyond just central fill
- Easy employee enrollment with proactive outreach
- Savings opportunities for non-traditional specialty diseases, including HIV
- More flexibility and lower costs

BlueCross BlueShield Kansas

PRIME THERAPEUTICS

bcbsks.com

Claim examples

Example Description	Claim Description	Total Cost	Employer Pays	Copay	Manufacturer Pays	Member Pay/Amount Applied to Accumulators
1	1st Claim – Default cost share	$4,500	$2,700	$1,800	$1,795	$5
2	Subsequent Claim 1 – Member-specific cost share	$4,500	$2,500	$2,000	$1,995	$5
2	Subsequent Claim 2 – Member-specific cost share	$4,500	$2,600	$1,900	$1,895	$5
3	Member exhausts funds	$4,500	$4,495	$5	-	$5
4	Member opt-out	$4,500	$2,700	$1,800	-	$1,800

Examples meant to illustrate the breakout of dollars on a RexAccess claim/scenario.
Amounts shown are hypothetical and could vary; manufacturer assistance program rules subject to change.

1. Member's first claim before they have a member specific record will apply a default copay along with the accumulator share associated with the residual amount necessary for the member to pay as part of that drug's assistance program.
2. Subsequent claims will be evaluated, and the member copay could be updated as necessary to apply the optimized amount on their next claim.
3. Part of the claim-by-claim evaluation is to try and prevent the member from running out of funds, though it could still happen. If the member does run out of funds their experienced is kept the same, paying the same amount as they were when using assistance.
4. Members who decide to opt out will experience a full copay and will get credit for that full amount toward their accumulators.

Contact your Blue Cross and Blue Shield of Kansas representative for more information.

COPAYS AS LOW AS $0

SAVINGS OPPORTUNITIES UP TO $10 PMPM[2]

[1] If your state has an anti-accumulator law, Prime will work with you on an alternative design.
[2] Prime internal ASO book of business data 2021. Savings may differ depending on current benefit design.

Visit us at bcbsks.com

BlueCross BlueShield Kansas

PRIME THERAPEUTICS

1133 SW Topeka Blvd, Topeka, KS 66629

Dental Insurance Plan

Insured by Delta Dental of Kansas

Maximum	**$1,500 per person per calendar year**
Preventive & Diagnostic **No Deductible – 100% Payment**	Oral examinations: two times per Calendar year Diagnostic x-rays: bitewing two times per Calendar year for dependents under age 18 and once each 12 months for adults age 18 and over Full mouth x-rays or panoramic x-rays: once each 5 years **Prophylaxis (cleanings): unlimited** Topical fluoride: two times per Calendar year for dependents under 19 Space maintainers: only if under age 14 and only for premature loss of primary molars Sealants: once per lifetime if under age 16 when applied to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact
Deductible	$25.00 per person per calendar year $75.00 maximum per family per calendar year *Deductible does not apply to Diagnostic and Preventive procedures
Basic Services **After Deductible – 80% Payment**	- 1 emergency examination per year by dentist for the relief of pain - Extractions and other oral surgery including pre & post operative care - Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; & stainless steel crowns for dependents under 12 - Procedures for root canal treatments and root canal fillings a) Includes procedures for the treatment of diseases of the tissues supporting the teeth; Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis b) Surgical periodontal procedures
Major Services **After Deductible – 50% Payment**	- When teeth cannot be restored with a filling material, provides individual crowns. - Bridges, partial and complete dentures, includes repairs and adjustments. - Implants
Right Start 4 Kids (RS4K)	The Right Start 4 Kids by provides children 12 and under, 100% coverage, with no deductible, for all services covered under the plan (excluding orthodontics) when an in-network dentist is seen.
Orthodontics	Not Covered
Dependents	Covered up to age 26

TO FIND CONTRACTING DELTA DENTAL PROVIDERS:

1. Go to: **www.deltadentalks.com** and click on "Find a Dentist"
2. Select the "Specialty" and under "Your Plan" select "Delta Dental Premier" then click "Find Dentists"

Once you are logged in, you can also view your benefits, print an ID card, use the Delta Cost Estimator to estimate procedure costs & review your claims!

Voluntary Vision Plans

Insured by Surency Life and Health

OPTION 1 – Exam & Materials

Services	In Network Member Cost	Out of Network Allowances
Vision Exam with dilation as necessary	$10	$35
Retinal Imaging	Up to $39	N/A
Contact Lens Fit & Follow-up: *(contact lens fit & 2 follow-up visits are available once a comprehensive eye exam has been completed)*		
Standard- spherical clear contact lenses in conventional wear & planned replacement (examples include but not limited to disposable, frequent replacement, etc.)	$40	$0
Premium- all lens designs, materials & specialty fittings other than Standard Contact Lenses (examples include toric, multifocal, etc.)	10% off Retail	$0
Frames: any available frame at provider location	$130 Allowance	$65
Standard Plastic Lenses:		
Single Vision	$25 copay	$25
Bifocal	$25 copay	$40
Trifocal	$25 copay	$55
Lenticular	$25 copay	$55
Lens Options:		
Standard Polycarbonate	Adults: $40 Dependents under 19: $0	$25 $25
UV Coating	$15	Not Covered
Tint (Solid & Gradient)	$15	Not Covered
Standard Scratch-Resistance	$15	Not Covered
Standard Anti-Reflective Coating	$45	Not Covered
Standard Progressive (Add-On to Bifocal)	$90	$40
Premium Progressive (Add-On to Bifocal)	$110 - $135	$40
Other Add-Ons & Services	20% off Retail Price	Not Covered
Contact Lenses: -Contact lens allowance includes materials only -Allowance not available if eyeglasses are elected		
Conventional	$130 Allowance, 15% off Balance over $130	$100
Disposable	$130 Allowance	$100
Medically Necessary	$0	$200
Additional Pairs Benefits:	40% discount off complete pair of eyeglass purchase & 15% off conventional contact lenses	N/A
Laser Vision Correction For Lasik providers call 1.877.5LASER6	15% off retail price or 5% off promotional price	N/A

Voluntary Vision Plans

Insured by Surency Life and Health

OPTION 2 - Materials Only

Materials Covered	In Network	Out of Network
Frames, Lens & Options Package: *Any frame, lens & lens option available at provider locations*	$200 Allowance for Frame, Lens & Lens Options, 20% off Balance over $200	$200
Contact Lens: *(in lieu of frames, lens & options package)*	$200 Allowance	$200

- ***Service frequencies are computed by calendar year, not date of service.***
- ***A child is eligible for coverage under the plan if the child is under age 26.***

Note: Generally, Medicare does not cover eyeglasses or contact lenses.

To find an In Network Provider:

1) Go to www.surency.com and select "Surency Vision"
2) Select "Find a Provider near you"
3) **For Option 1—Exam & Materials, select the "Insight Network"**
   For Option 2—Materials Only, select the "Access Network"
4) Enter your location and click "Get Results"

****If you choose a provider out of network, you will need to file a claim for reimbursement.*****

Life and AD&D Insurance Plan

Insured by Guardian

Paid 100% by Employer

Employee

Life Insurance .....150% of Annual Salary (Max $200,000)
AD&D.....150% of Annual Salary (Max $200,000)

(rounded to the next higher $1,000)

These benefits will be reduced 65% at age 65, an additional 25% at age 70, and an additional 15% at age 75.

Voluntary Life and AD&D Insurance Plan

Insured by Guardian

Employee Coverage –

The voluntary life insurance plan allows each employee the option to purchase additional life insurance coverage.

- **Guarantee Issue: $100,000** under age 65; age 65 – 69 $50,000; age 70+ $10,000
- Minimum: $10,000; Maximum: $200,000
- Increments of $10,000
- Matching Accidental Death and Dismemberment
- Coverage reduces 35% at age 65, an additional 25% at age 70, and an additional 15% at age 75.

Spouse Coverage –

Coverage for spouses is also available if the employee enrolls in the voluntary life insurance plan.

- Guarantee Issue: **$20,000** under age 65; age 65+ $10,000
- Minimum: $10,000; Maximum: $200,000 (not to exceed 100% of Employee's amount)
- Increments of $5,000
- Matching Accidental Death and Dismemberment
- Coverage reduces 35% at age 65, an additional 25% at age 70, and an additional 15% at age 75.

***Note- Spouse premiums will be calculated based on employee age**

Children Coverage -

- Guarantee Issue: 14 days to 26 years
- $10,000 benefit (not to exceed 100% of Employees amount)
- Coverage is available if the employee enrolls in the voluntary life insurance plan.
- Matching Accidental Death and Dismemberment

This benefit provides coverage for all dependent children regardless of the number of children.

Plan Highlights:

- Will Prep Services: Provides resources to prepare wills and other planning documents.
- Enhanced AD&D Features: Child Education Benefit, Catastrophic Loss, Education & Retraining Benefit, Seatbelt & Airbag Benefit

Voluntary Life and AD&D Insurance Plan

Insured by Guardian

EMPLOYEE & SPOUSE RATES PER $1,000	
<30	0.0325
30-34	0.0325
35-39	0.0525
40-44	0.0775
45-49	0.1125
50-54	0.1975
55-59	0.3025
60-64	0.3125
65-69	0.5375
70-74	1.1875

ALL CHILDREN RATE TABLE	
$10,000	$1.13

- Rates shown are per pay period
- Spouse premiums are calculated based on Employee age
- Rates can adjust once each year on the program anniversary date at each five year age band.
- The voluntary plan is portable, includes waiver of premium, includes accelerated life benefit, and conversion is available when the insurance terminates.

Use this formula to calculate your premium:

Semi-Monthly Rate Per $1,000	x	Benefit in $1,000's	=	Semi-Monthly Cost

OPEN ENROLLMENT

You may elect coverage for you and your spouse up to the **Guaranteed Issue Amount** when you are first eligible to enroll.

For future open enrollment periods if you enrolled for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for an increase of coverage, by an electable amount up to $50,000 not to exceed the Guarantee Issue.

Any late enrollees will have to complete a medical questionnaire (EOI).

Online Evidence of Insurability (EOI)

Insured by Guardian

EOI's that need to be completed for **Voluntary Life Insurance**, can be completed online.

Follow the steps below:

1. Go to guardiananytime.com/eoi
2. Click "Yes, I have read and agree to the Disclosure Statement"
3. Enter Group ID : 00555477
4. Select the coverages you are applying for and sill in your current and new election amounts.

Tip: Enter "0" for current amount if this is a new election or if this is a request to increase your short term disability or long term disability coverage.

3-1 Supplemental Health Plan

Insured by Guardian

The Supplemental Health Plan is three plans rolled into one – Hospital Indemnity, Accident, and Critical Illness! This plan provides benefits to help cover additional or unexpected medical costs. The benefits pay directly to you, and are not tied to the medical plans.

Critical Illness Plan

The Critical Illness Plan helps prepare you for the added costs of battling a specific critical illness. As the recovery process begins, most people begin to worry about the bills that have piled up. Our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness

Benefit Amount (50% reduction at age 70)	**Employees:**	**$5,000**
	Spouse:	**$5,000**
	Dependent Children:	**$2,500**

	Illness	1st Occurrence	2nd Occurrence
Covered Conditions (lump sum payments)	**Cancer**		
	Invasive Cancer	100%	50%
	Carcinoma In Situ	30%	0%
	Benign Brain Tumor	75%	0%
	Skin Cancer	$250 per lifetime	Not Included
	Vascular		
	Heart Attack	100%	50%
	Stroke	100%	50%
	Heart Failure	100%	50%
	Arteriosclerosis	30%	0%
	Other		
	Organ Failure	100%	50%
	Kidney Failure	100%	50%
Cancer Vaccine	$50 per lifetime for receiving a Cancer Vaccine		

Pre-Existing Condition Limitation: 3 month look back period, 12 month exclusion period;
Any sickness or injury for which the insured person received treatment within 3 months prior to the effective date won't be covered for the first 12 months of the policy.

3-1 Supplemental Health Plan

Insured by Guardian

Accident Plan

Guardian's Accident Plan provides benefits to help cover the costs associated with unexpected medical bills. When you have an accident the costs add up quickly. The plan pays you the benefit regardless of any other insurance and it is 24 Hour Coverage, on or off the job!

Emergency Care Benefits:	
Ambulance Transportation	$100 Ground, $500 Air
Emergency Treatment	$150
Diagnostic Examination	$100 per CT/MRI scan
Initial Physician Office Visit/ Urgent Care	$50
General Treatment Benefits:	
Initial Hospital Admission	$750
Initial ICU Hospital Admission	$1,500
Hospital Confinement	$175 per day, 365 days maximum
ICU Confinement	$350 per day, 15 days maximum
Rehabilitation Facility Confinement	$150 per day, 15 days maximum
Follow-up Physician Office Visit	$25 up to 6 treatments
Specified Injury & Treatment Benefits:	
Fractures	Up to $4,500
Dislocations	Up to $3,600
Burns (2nd & 3rd Degree)	Up to $12,000 Skin Graft 50% of burn benefit
Coma	$7,500
Concussion	$50
Lacerations	Up to $300
Child Organized Sport	20% increase to child benefits if injury due to an organized sport
Additional Benefits Include	Rehab, X-Ray, Surgery, Lodging, and Family Care
Wellness Benefit:	$50 per covered person, per calendar year, for completing a Wellness Screening. This would include the employee, spouse, and any covered children!

Eligible Wellness Screenings Include:

- Routine Annual Physical
- Immunizations
- Mammography
- Fasting blood glucose test
- Chest X-ray, Colonoscopy, Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test (HDL and LDL)
- Stress test bicycle or treadmill

**See Plan Summary for complete list.*

3-1 Supplemental Health Plan

Insured by Guardian

Hospital Indemnity Plan

The Hospital Indemnity plan provides benefits to help cover the costs associated with a hospital stay.

Hospital Admission	$1,000 per admission to a max of 1 admission per year per insured (hospitalization due to sickness only)
Hospital Confinement	$100 per day; Maximum of 15 days per year, per insured
Pre-Existing Condition Limitation: 3 month look back period, 12 month exclusion period; Any sickness for which the insured person received treatment within 3 months prior to the effective date won't be covered for the first 12 months of the policy.	

Plan Highlights:

- Portability allows the employee to take the coverage with them even if employment has ended.
- Employees over the age of 69 are not eligible to enroll in the Supplemental Health Package. After initial enrollment, Supplemental Health coverage will continue as long as an insured is actively at work.

Exclusions include but are not limited to:

· Suicide or Self-Inflicted Injury
· Elective Surgery
· Gastric or Intestinal Bypass Services
· Cosmetic Surgery

Long Term Disability

Insured by Guardian

100% EMPLOYER PAID

- Monthly Benefit – 60% to $10,000
- Elimination Period – 90 days
- Duration – Social Security normal retirement age
- Pre-Existing Condition – 3 months prior, 12 months after exclusion

Eligible employees will automatically be enrolled in the employer paid Long Term Disability Plan.

Along with this coverage, employees also have access to Guardian's **Employee Assistance Program.** There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program (EAP) which includes WorkLife Matters and is available to you and your family in connection with your group insurance from Guardian. It's confidential — information will be released only with your permission or as required by law.

Employee Assistance Program (EAP) Consultative Services

- Telephonic Counseling – Unlimited, 247/ consultations with master's and doctoral-level counselors
- Face-to-Face Counseling – Up to 3 visits per employee/household member per year
- Tobacco Cessation Coaching – Unlimited telephonic support an resources to assist with tobacco cessation

Work/Life Assistance & Resources

- WorkLife Services – Unlimited 24/7 access to WorkLife Specialists (subject matter experts) in the areas of: family and care giving, health and wellness, emotional well-being, daily living, and balancing work/life responsibilities.
- Child and Elder Care Referral – Unlimited telephonic consultation with a WorkLife Specialist (part of WorkLife Services)

Legal/Financial Assistance & Resources

- Legal Consultation – Unlimited telephonic support an free initial 30 minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms
- Financial Consultation – Unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching
- ID Theft – Free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution an education
- Will Prep/Legal Document Preparation/Tax Consultation

To contact the EAP:
Phone: 1-800-386-7055 (Available 24 hours a day, 7 days a week)
Website: www.IBHWORKLIFE.com (Username – Matters; Password: wlm70101)

Flexible Spending Accounts

Administered by Surency FLEX

The Internal Revenue Code Section 125 allows an employer to establish a salary reduction agreement for the benefit of employees. The employee's portion of the insurance premiums, eligible health care and dependent care expenses are deducted from the employee's "gross income" before taxes are calculated. The amount of taxes withheld uses the lower "net taxable income" amount. Since deductions are before taxes are calculated, the employee's taxable income is reduced. The employee's take-home pay increases because federal and state income tax, FICA and Medicare tax are not paid on the amount deducted.

PREMIUM SAVINGS PLAN allows you to pay for your share of the group health and dental insurance premiums on a before-tax basis. You may not stop the deductions or change how you enroll in these plans unless you have one of the below status changes.

- Termination of employment
- Spouse changes jobs
- Birth or adoption of a child
- Child no longer eligible
- Change of marital status
- Death of a dependent

Other reasons may be within the provisions of the plan. The plan administrator must approve all changes.

FLEXIBLE SPENDING ACCOUNTS (FSA):

FSA's operate on a plan year basis. Each year you must elect to participate in the Flexible Spending Account. You estimate the amount of eligible expenses you and your dependents will likely incur, and from this amount, determine how much you would like to set aside in the Flexible Spending Account.

MAXIMUM ANNUAL CONTRIBUTION: $3,200 per year/per-tax

CARRY OVER:

Up to $640 (UPDATED AMOUNT) of unused amounts in a current plan year's health flexible spending arrangement (FSA) can be "carried over" to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year. **Any amount over $640 will be forfeited.**

****IMPORTANT INFORMATION** - You are required to re-enroll in the FSA during Open Enrollment in order to use your Carry Over funds for the following plan year. If you do not re-enroll, your remaining balance will be forfeited.

QUICK FACTS:

- You **do not** have to be enrolled in a medical plan to participate in a FSA!
- In most cases, you can also use your FSA money to pay for expenses incurred by your spouse and dependents (up to age 26).
- You can only use your FSA money to pay for expenses which incur within the plan year.
- The amount you contribute from your paycheck cannot be changed up or down during the year unless you have a qualified election change event.

Flexible Spending Accounts

Administered by Surency FLEX

Most expenses applied to the deductible, coinsurance or copay of your health benefit plan can be submitted for reimbursement. For example, your health plan contains office visit and prescription drug copays. Consider depositing money in the Flexible Spending Account so you can pay those expenses with tax-free dollars. **Call 866-818-8805 or visit Surency.com to view a complete list of eligible expenses.**

COMMON FSA ELIGIBLE EXPENSES		
Abortion	Eyeglasses (Prescription & Reading)	Ovulation Kits
Acupuncture	Fertility Enhancement	Oxygen
Adult Diapers	Guide Dog	Physical Therapy
Alcohol/Drug Treatment	Hearing Aids (& Batteries)	Pregnancy Test Kit
Ambulance	Home Care	Prescription Glasses
Artificial Limb/Teeth	Home Improvements	Prescription Medicines
Athletic Care	Hospital Services	Prosthesis
Bandages	Hot/Cold Therapy Packs	Psychiatric Care
Birth Control Pills	Infertility Treatments	Psychoanalysis
Blood Pressure Monitors	Laboratory Fees	Psychologist
Body Scan	Lactation Expenses	Smoking Deterrents
Braille Books & Magazines	Lasik Eye Surgery	Splints & Casts
Breast Pumps & Supplies	Lead-Based Paint Removal	Sterilization
Breast Reconstruction	Learning Disability	Sunscreen (SPF 15 or over)
Capital Expenses	Lifetime Care Payments	Surgery
Car (Special Hand Controls)	Long-Term Care	Telephone (Hearing Impaired)
Catheters	Medical Conferences	Therapy
Chiropractor	Medical Information Plan	Thermometers
Contact Lenses/Solutions	Mileage for medical trips	Transplants
Contraceptives	Nursing Home	Transportation (Medical)
Crutches	Nursing Services	Vasectomy
Dental Treatment	Optometrist	Vision Exams
Denture Adhesives/Repair	Organ Donors	Weight Loss (Program Fees)
Denture Pain Relief/Cleansers	Orthodontic Fees (braces)	Wheelchair
Diabetes Testing/Supplies	Orthopedic Supports	Wig (Hair Lost Due to Disease)
Diagnostic Devices	Osteopath	X-rays/Diagnostic Testing
OTC Medications: Written prescriptions are not required for Over the Counter (OTC) drugs, including items like Tylenol, Claritin, Tamiflu, etc. when purchased with an FSA or HSA.		
Menstrual Care Products: Menstrual care products, including items like tampons, pads, cup, etc. are eligible expenses under an FSA or HSA.		

Flexible Spending Accounts

Administered by Surency FLEX

INELIGIBLE FSA EXPENSES		
Burial/Funeral Expenses	Health Club Dues	Sunglasses (non-prescription)
Cosmetic Procedures	Household Help	Swimming Lessons
Dance Lessons	Illegal Treatments	Tanning
Diapers/Diaper Service	Insurance Premiums	Teeth Whitening
Electrolysis/Hair Removal	Maternity Clothes	Medicine (from Outside U.S.)
Fitness Programs	Piercings	Veterinary Fees
Future Medical Services	Nutritional Supplements/ Vitamins (Over-the-Counter)	Warranties (for Eyeglasses or Hearing Aids)
Exercise Equipment (unless prescribed)	Toiletries (Toothbrush, Toothpaste, etc.)	Weight-Loss Programs (unless prescribed)

DEPENDENT CARE ACCOUNTS

These accounts reimburse you for eligible dependent care expenses with tax-free dollars. This is a valuable plan for employees with children or dependent parents. The maximum amount you may set aside is **$5000.00** per plan year.

Expenses you may claim and be reimbursed with tax-free dollars include:

- Wages paid to a babysitter, whether the care is provided in or outside of your home. However, the babysitter may not be someone you claim as a dependent on your tax return and must be over 18 years of age. Expenses for a babysitter can only be used for services provided during regular working hours. Babysitting costs for social events are not eligible.
- Services of a day care center or nursery school, providing the center complies with state and local laws.
- Cost for care at facilities away from home, such as family day care or adult day care centers, as long as the dependent returns home for at least 8 hours of a 24-hour day.
- Wages paid to a care giver or home aide for providing eligible care.
- Any other qualified dependent care expenses as defined by the IRS.
- The debit card is not available for dependent care expenses (unless the provider has the specific capabilities)

The amount you contribute from your paycheck cannot be changed up or down during the year unless you have a qualified election change event.

Tips:

If you participate in a Dependent Care Account, you may contact Surency to complete a **Reoccurring Reimbursement Form.** The completed form will serve as an ongoing receipt for the entire plan year and you won't have to submit a receipt each time you pay the care provider!

The Visa card can only be used with a Dependent Care provider with a properly registered credit card processing system including the four digit Merchant Category Code of 8351 "Child Care Services" or 8299 "Schools and Educational Services". If the merchant's credit card terminal is not setup in this way, the card will not be accepted.

Flexible Spending Accounts

Administered by Surency FLEX

Surency Flex Benefits Card is a special-purpose Visa® Card that gives you an easy, automatic way to pay for eligible expenses. The Benefits Card lets you electronically access the pre-tax amounts set aside in your Surency FSA . Use it when paying for eligible expenses at a provider or merchant that accepts Visa Cards and uses an inventory control system. These transactions may be automatically substantiated, meaning you don't have to file a claim and may not have to submit a receipt. However, always keep all documentation for tax purposes or in case Surency requests further documentation.

HOW TO USE YOUR BENEFITS CARD

1) If purchasing multiple items, have the cashier ring up all of your items together.
2) When it's time to pay, swipe your Surency Flex Benefits Card first. Select 'credit' and sign for your purchase. Optional: In addition to your signature, you can set up a PIN number to access your funds by calling 866-898-9795. If you have a PIN number, select 'debit' and enter the PIN.
3) All eligible expenses will be paid for from your account and deducted from your total. If you are purchasing non-eligible items, you will need to have a second form of payment available for those items.
4) Keep your receipts in the event that further validation is needed.

DID YOU PAY OUT-OF-POCKET FOR AN ELIGIBLE EXPENSE?

Submit a claim to get paid back using money from your account. There are three ways to submit a claim:

1. SURENCY FLEX APP	2. MEMBER ACCOUNT	3. PAPER CLAIM FORM
Download the Surency Flex mobile app and submit the claim by taking a photo of your receipt.	Log into your Member Account at Surency.com to upload your receipt.	Visit Surency.com to download a paper claim form. Complete and return to Surency.

Online Account Access

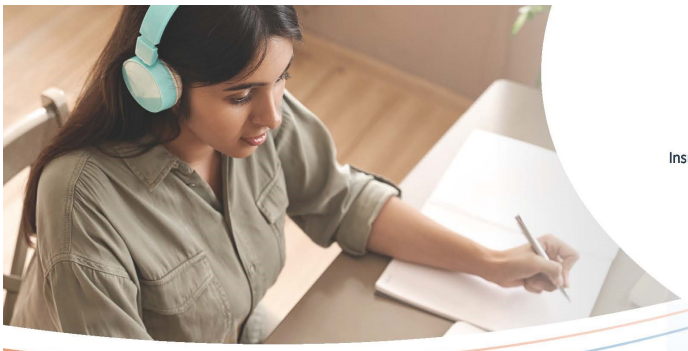
Create a Member Account at **Surency.com** or download the mobile app!

- Check balances on your Health Care Flexible Spending Account (FSA), Dependent Care Flexible Spending Account (DC FSA),
- View account activity, payment history and tax statements.
- Submit claims for expenses.
- Add or update a bank account to receive direct deposit reimbursements.
- Access account funds to pay yourself back or to pay your doctor.
- Report a Surency Flex Benefits Card as lost or stolen.

Surency FLEX
Download on the App Store
GET IT ON Google Play

On the Surency FLEX mobile app, you can snap photos of your receipts to submit with new or existing claims!

Benefit Advocate Center (BAC)



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Connect with Us

Wichita State University Intercollegiate Athletic Association, Inc.

Phone: (833) 295-9075
Email:
BAC.wsuofintercollegiateathleticassocadvocates@ajg.com

Hours of operation

Monday – Friday

7 a.m. – 8 p.m. Central Time

ajg.com The Gallagher Way. Since 1927.

Family and Medical Leave Policy

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- serious health condition that makes the employee unable to perform the essential functions of their job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty."

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may be also taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Family and Medical Leave Policy

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for the involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Women's Health & 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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Option 1 - $1,500 (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $3,000 deductible)

Plan 2: Option 2 - $5,000 High Deductible Health Plan (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 316-978-5388 or khegenauer@goshockers.com.

HIPAA Special Enrollment Notice

Wichita State University Intercollegiate Athletic Association, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Wichita State University Intercollegiate Athletic Association, Inc. Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (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).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kent Hegenauer - Chief Financial Officer/Senior Associate Athletic Director or at 316-978-5388 or khegenauer@goshockers.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Wichita State University Intercollegiate Athletic Association, Inc. is committed to the privacy of your health information. The administrators of the Wichita State University Intercollegiate Athletic Association, Inc. Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kent Hegenauer - Chief Financial Officer/Senior Associate Athletic Director at 316-978-5388 or khegenauer@goshockers.com.

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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Cobra

A temporary extension of health benefits may be available to you at group rates in certain instances where coverage under the plan would otherwise end. Covered individuals experiencing a qualifying event resulting in a loss of group health plan coverage may continue coverage as outlined in the chart below. Your coverage will be billed directly from the insurance company. Both the health plan and the dental plan can be continued under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. For more information about the Marketplace, visit www.HealthCare.gov.

Qualifying Event	Qualified Beneficiary	Number of Months
The employee terminates employment or hours are reduced.	Employee and all covered dependents.	18
The employee loses coverage because the employer files for Chapter 11 bankruptcy.	Employee and all covered dependents.	18
The employee becomes disabled.	Employee and all covered dependents.	29
The employee becomes eligible for Medicare due to age while on COBRA.	Qualified beneficiaries of the covered employee.	36
The employee's death.	Dependents of covered employee.	36
Divorce or legal separation.	Dependents of covered employee.	36
Dependent child no longer qualifies as a dependent (e.g., reaches the maximum dependent age, gets married, etc.).	Dependent child.	36

Notice of CHIPRA Policy

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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

Notice of CHIPRA Policy

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

Notice of CHIPRA Policy

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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 & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Notice of Creditable Coverage

Important Notice from Wichita State University Intercollegiate Athletic Association, Inc.

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 Wichita State University Intercollegiate Athletic Association, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Wichita State University Intercollegiate Athletic Association, Inc. has determined that the prescription drug coverage offered by the medical 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 Wichita State University Intercollegiate Athletic Association, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Wichita State University Intercollegiate Athletic Association, Inc. 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 Wichita State University Intercollegiate Athletic Association, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Wichita State University Intercollegiate Athletic Association, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 01, 2024**
Name of Entity/Sender:	**Wichita State University of Intercollegiate Athletic Association, Inc.**
Contact—Position/Office:	**Kent Hegenauer - Chief Financial Officer/Senior Associate Athletic Director**
Office Address:	**1845 Fairmount St** **Wichita, Kansas 67260-9700** **United States**
Phone Number:	**316-978-5388**

Bi-Weekly Payroll Deductions (24 Deductions)

Beginning January 1, 2024

Medical & Dental Plans	Deductions
OPTION 1 - $1,500	
Employee Only	$82.37
Employee + Spouse	$281.28
Employee + Child(ren)	$262.04
Family	$452.33
OPTION 2 - $5,000 HDHP	
Employee Only	$47.80
Employee + Spouse	$206.96
Employee + Child(ren)	$192.00
Family	$342.54

Vision Insurance Plans	Deductions
Option 1 - Exam & Materials	
Employee Only	$4.97
Employee + Spouse	$9.73
Employee + Child(ren)	$8.68
Family	$13.45
Option 2 - Materials Only	
Employee Only	$4.87
Employee + Spouse	$9.54
Employee + Child(ren)	$8.51
Family	$13.18

3in1 Supplemental Plan	Deductions
Employee Only	$12.78
Employee + Spouse	$25.35
Employee + Child(ren)	$19.20
Family	$32.06

Bi-Weekly Payroll Deductions (24 Deductions)

Beginning January 1, 2024

Basic Life Insurance Plan	**100% Employer Paid**
Voluntary Life Insurance Plan	**100% Employee Paid** **(See page 14 for rates)**
Long Term Disability Insurance Plan	**100% Employer Paid**

Carrier Contacts

Blue Cross Blue Shield of Kansas

Member Services: 1-800-432-3990

Website: www.bcbsks.com

- Order a new ID card
- Change/switch your Primary Care Physician
- Questions regarding deductibles, coverage & claims

Delta Dental of Kansas

Member Services: Local: 316-264-4511
1-800-234-3375

Website: www.deltadentalks.com/Subscribers

Download the Delta Mobile App!

- Find in-network dentists
- Access your ID card
- Review claims & coverage

Surency Vision

Member Services: 1-866-818-8805

Website: www.surency.com/Members/SurencyVision/

Download the Surency Mobile App!

- Find in-network providers
- Access your ID card
- Review claims & coverage

For questions about your claim, contact: EyeMed Vision Care at 1-866-939-3633

Carrier Contacts

Surency FLEX - FSA		**Download the Mobile App!**
Member Services:	1-866-818-8805	· Check account balance
Website:	https://www.surency.com/flex/fsa	· View & submit claims
Email:	flex@surency.com	· Submit receipts

Guardian	
Customer Service:	888-482-7342
Website:	www.guardianlife.com

Gallagher Benefit Services	
Phone:	833-295-9075
Fax:	316-685-5520
Website:	www.ajg.com
BAC Email:	wsuofintercollegiateathleticassocadvocates@ajg.com

Helpful Tools

GoodRx		**Download the Mobile App!**
Good Rx collects & compares prices from over 70,000 pharmacies. You can also find discounts and print free coupons.		
Website:	www.goodrx.com	

FSAstore

FSAstore is the largest online marketplace for guaranteed FSA-eligible products along with educational resources. You can search eligible items and shop on the website.

Website: www.fsastore.com

Booklet Prepared by:

Gallagher

Insurance | Risk Management | Consulting