WESTERN DAKOTA TECHNICAL COLLEGE

Western Dakota Technical College

2025 rev. 5/1/2025

Employee Benefits Guide

Welcome to the Western Dakota Technical College employee benefits program. It is our pleasure to provide you with a revised copy of the 2025 Employee Benefits Guide. Its purpose is to acquaint you with the benefits that are available to employees of Western Dakota Tech and their families. We hope that you find this guide useful as you explore your benefits options.

Western Dakota Technical College is committed to offering choices that provide quality benefits for you and your dependents. We are also responsible for maintaining the competitiveness of our business. A successful organization is the key to creating opportunity and security for our employees.

Both the Western Dakota Technical College and our employees have a critical role in managing health care costs. That involves shared responsibility, shared risk-taking and our taking an active role in understanding, utilizing and purchasing health care services.

Your benefit choices are important decisions and affect how you receive your benefits and what you pay for them. Take the time to make sure you fully understand the plans available to you.

We encourage you to keep this guide in a convenient location, along with your other benefits information, so that it is easily accessible as you may want to refer to it periodically. If you misplace your copy of this guide, you may request information from the carriers or download a new copy from the Employee Navigator benefits system.

Human Resources is here to assist you and answer any questions you may have.

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This booklet contains informed guidance to help you choose the best benefit options for you are your family members (if applicable), however this is a brief description only and not a Certificate of Coverage. Please see the applicable Group Policy's and the Summary of Benefits and Coverage (SBC) which, alone, determines all rights, benefits and applicable Limitations and Exclusions

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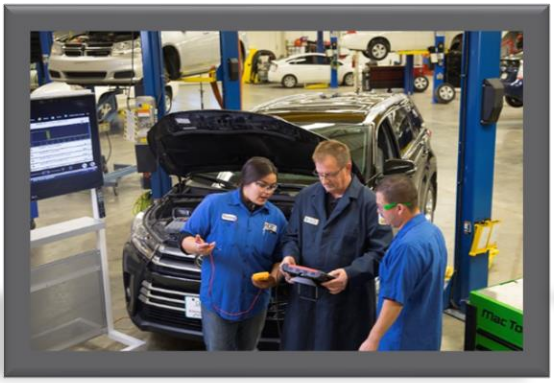
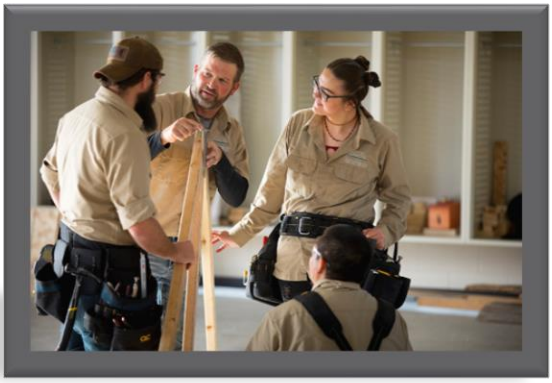
Your Benefit Choices

Western Dakota Technical College strives to provide a wide variety of benefits for our employees. Some benefits are provided automatically at no cost while others are available if you choose them. Check the guide below to see which benefits you need to make a successful program designed just for you.

Keep this booklet and all coverage materials easily accessible, so that you may refer to them if necessary.

BENEFIT	VENDOR	WHO PAYS THE COST
Medical & Rx Insurance	Wellmark EBS	WDTC & Employee
Dental Insurance	Delta Dental	WDTC & Employee
Flexible Spending Accounts	wex	WDTC & Employee
Base Term Life and AD&D Insurance	TheStandard	WDTC
Supplemental Term Life Insurance		Employee
Voluntary Short-term Disability		Employee
Voluntary Accident Insurance		Employee
Voluntary Critical Illness		Employee
Employee Assistance Program	HealthAdvocate	WDTC





EMPLOYEE ELIGIBILITY

WDTC employees who are employed in permanent positions that require 20 or more hours of work per week, or 86 hours a month on average, are eligible for benefits. Employees who are employed in temporary positions that require 30 or more hours of work per week, or 130 hours a month, on average are eligible for benefits.

Please note: Eligible WDTC staff does not include federal work study students, independent contractors or consultants, and Board members.

SPOUSE & DEPENDENT CHILD ELIGIBILITY

If you are an eligible participant, you may also cover your eligible spouse and/or dependent(s) under the medical, dental, life, accident and critical illness insurance plans. Eligible dependents include your:

- Lawful Spouse as determined under federal and state law.
- Dependent Children under the age of 26, including:
  - A biological child.
  - Legally adopted or placed for adoption (that is, subscriber assumes a legal obligation to provide full or partial support and intended to adopt the child).
  - A child for whom the Subscriber has legal guardianship.
  - A stepchild.
  - A foster child.
  - A biological child a court orders to be covered.

In addition, a child must be one of the following:

- Under age 26
- An unmarried full-time student under age 30 enrolled in an accredited educational institution. Full-time student status continues during:
  - Regularly-scheduled school vacations; and
  - Medically necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end
- An unmarried child who is deemed disabled. The disability must have existed before the child turned age 26 or while the child was a full-time student under age 30. Wellmark considers a dependent disabled when he or she meets the following criteria:
  - Claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's or retiree's tax return; and
  - Enrolled in and receiving Medicare benefits due to disability; or
  - Enrolled in and receiving Social Security benefits due to disability

BENEFITS EFFECTIVE DATE

Once the enrollment application is completed via the Western Dakota Technical College Employee Navigator system, coverage will be effective on the first day of the month following the first day of employment; or on the date of your other qualifying event if applicable.

ENROLLMENT & CHANGES

There are three conditions in which you may enroll and/or change your pre-tax benefit elections*.

- Upon hire (Includes employees that move from part-time to full-time)
- During Annual Enrollment
- Upon Qualifying life events (see next section for more details)

If you do not enroll by your initial eligibility date, the annual enrollment period is the only time that you can make changes to your benefit plans during a plan year. However, if you have a qualified family status change, you may be eligible to update certain benefit plans. If you experience a status change, you must make your change in election within 31 days of the date of the event or wait until the next annual enrollment. Please choose your benefits carefully.

QUALIFYING LIFE EVENTS

The elections that you make during your initial benefits eligibility period, or during the Annual Open Enrollment period, will remain in effect for the entire plan year. During that time, if your life or family status changes according to the recognized events below, you may be permitted to revise your benefits coverage to accommodate your new situation.

IRS regulations govern under what circumstances you may make changes to your benefits, which benefits you can change, and what kind of changes are permitted.

- All changes must be consistent with the qualified life event.
- Changes must be accompanied by supportive documentation.
- In most cases, you cannot change your benefit plan but may modify the level of coverage (In other words, you can add or delete dependents, enroll or dis-enroll yourself or dependents, but not switch carrier or plan).
- Any changes in benefit levels must be completed within 31 days of the event.

Recognized Qualifying Events:

- Marriage
- Death of spouse
- Divorce
- Spouse gains or loses coverage from another source
- Spouse's employer's Open Enrollment
- Birth or adoption of child
- Death of dependent child
- Dependent becomes ineligible for coverage

To request a change to your benefits due to a Qualifying Event, login to your Employee Navigator account and follow the prompts. Please note that you will be required to provide documentation for your qualifying life event to Human Resources, in addition to making your change in Employee Navigator Human Resources can also assist you in this process if needed.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/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 towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you 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 31 days after the marriage, birth, adoption, or placement for adoption. For more information regarding special enrollment rights, please contact Human Resources.

**You do have up to 60 days to request enrollment after the loss of Medicaid coverage.*
***Notify your employer or group sponsor within 60 days in case of the following events:*

- *Divorce, legal separation, or annulment.*
- *Your dependent child loses eligibility for coverage.*
- *You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP).*
- *You become eligible for premium assistance under Medicaid or CHIP.*

ENROLLMENT FAQS

What if I lose eligibility for benefits due to a change in my employment status?

Continuation of health care coverage (at your expense) is available to you and your covered dependents under federal COBRA law if you lose eligibility for benefits due to a reduction in hours, termination of employment, or leave of absence. Health coverage includes medical, dental and vision coverage.

Summary Plan Descriptions

We are required by law to make sure every employee has access to the Summary Plan Descriptions. If you have any questions about the benefits, please call your customer service number found at the back of your insurance card (if applicable) or Human Resources.

Important Information

Due to IRS regulations, the choices you make now with pre-tax premium elections **must** continue to be deducted until the end of the plan year (December 31) unless you have a qualifying event or status change.

This booklet contains informed guidance to help you choose the best benefit options for you and those you care about. For more detailed information, you should refer to the Summary Plan Description provided by each insurance company. If you do not receive a Summary Plan Description, please contact Human Resources

Medical Insurance

Insurance Carrier: Wellmark BlueCross BlueShield of South Dakota
Phone: 800.831.4818
Website: www.wellmark.com
Plan Type: Preferred Provider Organization (PPO)

		Monthly Pre-Tax Deductions	
Coverage Tier	**Monthly Plan Cost**	**Employee Cost**	**WDTC Cost**
Employee Only	$800.43	$116.85	$683.58
Employee + Spouse	$1,618.47	$538.52	$1,079.95
Employee + Child(ren)	$1,494.26	$495.40	$998.86
Family	$2,399.37	$801.89	$1,597.49

Important Health Plan Terms

- **Deductible**: The amount you must pay towards the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each plan are listed in the Summary of Benefits and Coverage document as well as on pages 6 of this booklet.
- **Out-of-Pocket Maximum**: The most each person must pay each year towards the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the calendar year. Penalties, legal fees, and interest charged by providers, expenses for non-covered services, charges for transplant services at non-designated facilities and charges over plan limits do not count toward the out-of-pocket maximum.
- **Coinsurance**: The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles until you reach your out-of-pocket maximum.
- **Copays**: The dollar amount you must pay for certain covered services. The Summary of Benefits and Coverage lists the copays and services that require them.
- **Benefit Coverage**: The percentage of the claim that will be paid by the Plan for covered services once the calendar year deductible has been satisfied and prior to the out-of-pocket maximum limit reached.

Wellmark BCBS of SD PPO + EBS Medical Bridge Plan

This is not a full listing of covered services and benefits. Please see the Wellmark and EBS Summary of Benefits of Coverages for more information.

Partial Listing of Covered Services	In-Network Benefits	Out-of-Network Benefits
Deductible per Calendar Year	$1,250 per member $2,500 per family	$1,250 per member $2,500 per family
Out-of-Pocket Maximum Per Calendar Year	$3,000 per member $6,000 per family	Medical: $8,350 per member $14,700 per family Rx: $6,350 per member $12,700 per family

Common Medical Event	Services You May Need	In-network *	Out-of-Network*
If you visit a health care provider's office or clinic	Primary care visit to treat injury / illness	$25 copay / visit	50% coinsurance
	Specialist visit	$50 copay / visit	50% coinsurance
	Doctor on Demand	$25 copay / visit	N/A
	Chiropractic Care (Office Visit)	$25 copay / visit	50% coinsurance
	Preventive care/ screening/ immunization	No charge	50% coinsurance
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance
If you need drugs to treat your illness or condition	Tier 1	25% coinsurance up to $100	Not Covered
	Tier 2	35% coinsurance up to $200	
	Tier 3	45% coinsurance up to $300	
	Tier 4	45% coinsurance up to $300	
	Specialty Drugs – Generic/Preferred	35% coinsurance up to $67	
	Specialty Drugs – Non-preferred	45% coinsurance up to $100	
If you have outpatient surgery	Facility fee (ambulatory surgery center)	30% coinsurance	50% coinsurance
	Physician / Surgeon Fees	30% coinsurance	50% coinsurance
If you need immediate medical attention	Emergency room care	$200 copay and 30% coinsurance	
	Emergency medical transportation	30% coinsurance	30% coinsurance
	Urgent Care	$35 copay / visit	50% coinsurance
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance
	Physician / Surgeon Fees	30% coinsurance	50% coinsurance
If you are pregnant	Office visits	30% coinsurance	50% coinsurance
	Childbirth / delivery professional services	30% coinsurance	50% coinsurance
	Childbirth / delivery facility services	30% coinsurance	50% coinsurance

All copayment and coinsurance costs shown are after your deductible has been met, if a deductible applies.

Wellmark BCBS Pharmacy Benefits

Administered by Wellmark and CVS Caremark

It's easy to access your prescription drug benefits. Just present your Wellmark ID card at any network pharmacy when you have a prescription to fill.

How Pharmacy Benefits Work

You'll want to check your benefits document for specifics on how drugs are covered and what you'll pay for them. Generally, this is how your prescription drug plan helps you access safe and affordable medications:

1. You get a prescription from your provider to get medication for your condition.
2. Check the Wellmark Drug List on myWellmark.com to make sure the drug is covered and if there are lower cost alternatives.
3. Visit a network pharmacy with your prescription and your member ID card.
4. At the pharmacy, you will need to pay your cost share for your prescription, unless this is waived. Also, your plan may have a pharmacy deductible.
5. You don't need to complete any paperwork, as claims are filed electronically.

Opt to use network pharmacies

With Blue Rx Complete, you must fill prescriptions at network pharmacies. Depending on your network, you may have access to more than 60,000 participating pharmacies, including local pharmacies and most major chains. Find one near you at myWellmark.com.

Which Drugs are Covered?

Go to myWellmark.com to view the Wellmark Drug List to find which drugs are covered.

Where can I fill my prescription?

There are three options that make getting your prescription easy:

Retail - This is a local neighborhood or chain store pharmacy. Your plan only covers prescriptions filled at network pharmacies. Search for a network pharmacy on myWellmark.com.

Mail Order Service - Have your medications delivered right to your doorstep. Find details about mail order services on myWellmark.com. Or, let CVS Caremark walk you through registration with FastStart® by calling 866-611-5961.

1. Visit Caremark.com and select Register Now.
2. Create a new, unique user ID.
3. Set up your mail order and contact preferences, such as auto refill, text alerts, and payment information.
4. Easily access your pharmacy information through Caremark.com and myWellmark.com.

Specialty Pharmacy - Some high cost or complex medications must be filled by select specialty pharmacies. You can work directly with these pharmacies to have specialty drugs delivered to your home They also help you take your specialty drugs exactly how your doctor prescribed. Go to myWellmark.com to learn about specialty pharmacy providers and how to use their services.

Health Insurance Made Easy

Your personal health care information is at your fingertips with **myWellmark®** — no matter your location — with tools, resources, and insights to help you manage health care spending and live a healthier life.

GET THE INFORMAITON YOU NEED

Using your specific health plan benefits and a powerful suite of tools, **myWellmark®** helps you make informed decisions:

- Find an in-network provider near you
- Know what your visits will cost before you go
- See your doctor's quality score and patient rating
- Read reviews from other patients and leave your own

KNOW YOUR BENEFITS INSIDE AND OUT

- When it comes to your coverage and benefits, **myWellmark®** has you covered. You're able to:
- Keep track of services you've used
- Determine potential copay or coinsurance costs for in- and out-of-network services
- See how close you are to meeting your deductible and out-of-pocket maximums
- Choose how you would like to receive communications and important documents related to your benefits

KEEP TABS ON CLAIMS AND SPENDING

On your personalized **myWellmark®**, you'll see an at-a-glance overview of recent claims activity and whether a claim is paid, pending or denied (and why). Need more details, including your share of the cost? Just click on any claim.

YOUR HEALTH CARE – AT YOUR FINGERTIPS

Get easy, on-the-go access to tools, resources and insights that help you keep track of care costs and stay healthy.

It's all available in the **myWellmark®** mobile app. The best part? **IT'S FREE.**

With the mobile app, you can:

- Log in securely using fingerprint or facial recognition technology.
- View in-network providers and hospitals.
- Get health answers over the phone with one tap of a finger.
- Find the closest provider or facility and get driving directions.
- View and email your mobile ID card for easy, on-the-go access.

Get more from your health plan by registering at www.mywellmark.com

Wellmark BCBS programs designed to help you live a healthier life

dr. on demand

Visit a doctor on your smartphone, tablet or computer virtually anywhere, any time.

See a doctor in minutes. Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor on your schedule. Get treatment for issues such as:

Cold and flu - Bronchitis and sinus infections - Urinary tract infections - Sore throats – Allergies -Fever Headache - Pink eye - Skin conditions – and so much more!

Feeling Blue? Virtual Visits are here for you.

When it comes to coping with mental health, you're not alone. Virtual Visits can be available to you day or night all from the comfort of your home. Comfortable, connected, confidential!

As a part of your Wellmark BCBS health benefits, you can connect with a licensed therapist — or psychiatrist for more complex issues — to listen and help you find solutions. Ready when you are - Make time for you and your overall health and well-being by scheduling your Virtual Visit today.

- Easily scheduled appointments — flexible to YOUR schedule.
- Review hand-picked, board-certified providers and their profile.
- Accessible anywhere — at the office or from your home.
- Private and confidential.

VISIT DoctorOnDemand.com or CALL 800-997-6196

Real People. Real Help. 24/7

Life can get stressful sometimes. Like when your toddler has a fever at midnight, or you're trying to help an elderly parent schedule a medical appointment. Luckily, there's BeWell 24/7, a service exclusively for Wellmark members.

It's so much more than a nurse line. It's real help from real people 24/7. With BeWell 24/7, you'll have access to:

1. **HEALTH ADVOCACY** — Get personalized help coordinating care, locating specialists, scheduling home-care services, transferring medical records and more.
2. **NURSE SUPPORT** — Having side effects from a new drug? Want to better understand a diagnosis? A registered nurse can provide trusted insight and recommend next steps.
3. **CARE NAVIGATION** — Receive information from health professionals who can help you better understand your health condition and learn more about how Wellmark can help.

Whether you're a new parent with a list of questions, or you think you're having side effects from a new drug, there's someone ready to help at **844-84-BEWELL (239355).**

Wellmark BCBS programs designed to help you live a healthier life

Wellmark Pregnancy Support Program

A healthy beginning for your baby starts with you. We're here to help. Visit your doctor regularly, and take advantage of our free Pregnancy Support program to get support throughout your pregnancy. Wellmark's Pregnancy Support program is here for you through each stage of your pregnancy and beyond.

ROBUST DIGITAL RESOURCES — Just log in to myWellmark.com for 24/7 access to our helpful online resources. We've partnered with some of the most trusted sources to provide you with the information you need when you need it, including:

- WebMD's Pregnancy Assistant — Learn about the stages of your baby's growth and get support throughout your pregnancy from prenatal to postpartum.
- Count the Kicks — Keep track of your baby's normal patterns of movement in the third trimester.
- Text4baby — Learn about baby milestones, set appointment reminders and get safety information via text message.

ONLINE PREGNANCY ASSESSMENT — Let us know about your current pregnancy and health history to see if you may benefit from nurse support over the phone. It's available anytime through myWellmark.

ACCESS TO NURSES — Rather receive support throughout your pregnancy over the phone? You can request a call from an Advanced Care nurse by calling 800-552-3993 ext. 3727.

BEWELL 24/7SM PHONE SUPPORT — Call anytime, day or night, to connect with a real person who can answer your most pressing questions. We'll take the time to listen and address all your concerns. Call anytime: 844-84-BEWELL.

Get started with Pregnancy Support today! Log in to myWellmark.com or call 800-552-3993 ext. 3727

Blue365

Most people are grateful for insurance when something bad happens. But Wellmark Blue Cross and Blue Shield members are grateful for their insurance 365 days of the year. That's because they have Blue365®. Members get exclusive discounts on wellness products and services they use all the time, like fitness trackers, eyeglasses, and athletic shoes.

Register for Blue365 at Wellmark.com/Blue365. It's free and you can start saving right away. Browse the discounts and be the first to know about the latest deals to hit Blue365 through a weekly email sent right to your inbox.

IDX Identity: Safe Secure and Protected

Your Wellmark health insurance coverage keeps you safe, secure, and protected from more than the cost of health care. Just by being a member, you and your dependents have exclusive, free access to identity protection services called IDXTM Identity. It's just another way you get more as a Wellmark member.

Enroll in the IDX Identity protection services today to monitor your credit record, keep track of your online activity 24 hours a day, seven days a week and have access to complete identity recovery if fraudulent activity is found.

Get started with IDX Identity today! Log in to myWellmark.com or call 866-486-4812, and make sure you have your Wellmark ID card on hand!

Dental Insurance

Insurance Carrier: Delta Dental of South Dakota
Phone: 605.224.7345 or 877.841.1478
Website: www.deltadentalsd.com

		Monthly Pre-Tax Deductions	
Coverage Tier	**Monthly Plan Cost**	**Employee Cost**	**WDTC Cost**
Employee Only	$59.60	$4.04	$55.56
Employee + 1	$119.18	$31.46	$87.72
Family	$175.34	$46.31	$129.03

How do I find a participating dentist?

Finding a participating dentist is easy. Simply visit www.deltadentalsd.org and use the interactive Dentist Search tool or call Customer Service at (877) 841-1478.

Prevention Pays

The Prevention Pays feature exempts preventive care and some gum disease (periodontal) services from the calculation of the plan's annual maximum benefit. That means preventive services like exams, cleanings, x-rays, and periodontal maintenance cleanings are covered when the plan's annual maximum benefit has been reached. It also means more benefits are available to help pay for treatment procedures like cavity fillings, crowns, and root canals.

Health through Oral Wellness®

Health through Oral Wellness® is a unique program that adds benefits to your dental plan based on individual oral health needs. A Delta Dental network dentist trained in Health through Oral Wellness® will conduct a clinical risk assessment during a regular preventive visit. The assessment measures the risk and severity of periodontal disease, and the risk of tooth decay.

If the assessment determines a member is at risk for tooth decay, additional benefits include fluoride treatments, sealants, and oral hygiene instruction. If a member is at risk for periodontal (gum) disease, has periodontal disease or has had periodontal surgery, the member will be eligible for two additional cleanings* and four fluoride treatments.

If a member has any of the following health conditions, they are eligible for additional benefits.

- Diabetes (2 additional cleanings*)
- High-risk cardiac care (2 additional cleanings*)
- Kidney failure or dialysis (2 additional cleanings*)
- Cancer treatments - chemotherapy or radiation (2 additional cleanings* and 2 applications of fluoride varnish)
- Suppressed immune system (2 additional cleanings* and 2 applications of fluoride varnish)
- Rheumatoid arthritis (2 additional cleanings*)
- Stroke (2 additional cleanings*)
- Pregnancy (1 additional cleaning* during the time of pregnancy)

** Cleanings can either be a general cleaning (prophylaxis) or a periodontal maintenance cleaning. Periodontal maintenance cleanings are typically covered under the "Endodontics and Periodontics" category, not the "Diagnostic and Preventive Services" category.*

2025 Benefits at a Glance

	Participating Dentist
ANNUAL DEDUCTIBLE	$50 / person / coverage year not to exceed $150 / family
ANNUAL MAXIMUM BENEFIT[1]	$1,500 / person / coverage year
LIFETIME ORTHODNOTIC MAXIMUM	$1,500 / person
COVERAGE YEAR	January - December

[1]*All services (except Preventive Care and Braces) are subject to the Annual Maximum Benefit and will not be paid if your Annual Maximum Benefit has been reached.*

PREVENTIVE CARE – 100% Paid by Delta Dental

- Routine exams and cleanings
  - 2 per coverage year
- Bitewing x-rays
  - 2 per coverage year to age 19, and once per coverage year age 19 and over
- Full mouth/panoramic x-rays
  - 1 every five years
- Fluoride applications
  - 2 per coverage year up to age 19
- Space maintainers
  - Primary back teeth up to age 14
- Dental sealants
  - Unrestored 1st and 2nd permanent molars up to age 16

FILLINGS & EXTRACTIONS – 80% Paid by Delta Dental

- Silver and tooth-colored fillings. If a tooth-colored filling is used to restore back teeth, benefits are limited to the amount paid for a silver filling
- Stainless-steel crowns
- Extractions and other oral surgery
- Emergency treatment for relief of pain

ROOT CANALS & GUM DISEASE – 50% Paid by Delta Dental

- Root canals
- Treatment of diseases of the tissues supporting the teeth
- Periodontal maintenance cleanings. *These cleanings do not apply to the Annual Maximum Benefit.*

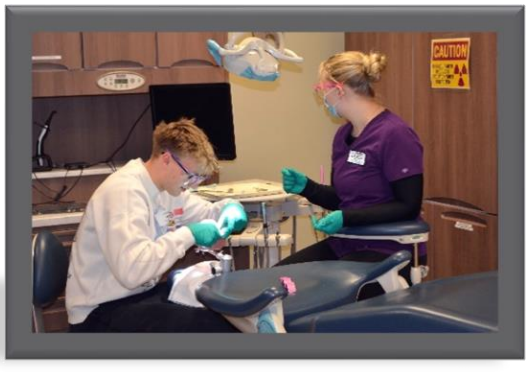
CROWNS & PROSTHETICS

- Crowns – 50% Paid by Delta Dental
- Bridges, dentures, and implants – 50% Paid by Delta Dental

BRACES & TEETH ALIGNMENT – 50% Paid by Delta Dental

- Treatment necessary for the proper alignment of teeth

Delta Dental will make an initial payment of $1,000 on an approved orthodontic treatment plan. A second payment of $500 will be made one year after the initial payment if coverage under this group number still exists.



Flexible Spending Accounts

Insurance Carrier: WEX
Customer Service: 866.451.3399
Claims Fax: 866.451.3245
Website: https://benefitslogin.wexhealth.com
Plan Year: January 1 - December 31

The Western Dakota Technical College Healthcare and Dependent Care Flexible Spending Accounts (FSAs) allow you to use tax-free dollars to reimburse yourself for a wide variety of healthcare and/or dependent care expenses that are not covered through your other benefit plans. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax (before federal and, in most cases, state and local income taxes are withdrawn).

Health Care FSA – maximum contribution is $3,300 per plan year

Health care expenses for yourself and your dependents – such as deductibles, coinsurance, co-pays, and eyeglasses – are eligible for reimbursement from your Health Care FSA.

Dependent Care FSA - maximum contribution: $5,000 per family* per plan year

Expenses for dependent care services for children under age 13, a disabled spouse, or incapacitated parent are eligible for reimbursement from your Dependent Care FSA as long as you incur them while you and your spouse work or attend school full-time.

**The maximum Dependent Care contribution is $5,000 per family, per year, as set by the IRS or $2,500 if you are married and filing a separate tax return.*

Rules and Regulations

Plan your annual FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year **(January 1 to December 31)** unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSAs:

- Eligible expenses must be incurred during the plan year.
- If you incur fewer expenses than expected, any remaining funds in your Dependent Care FSA and any balance above $660 in your Health Care FSA at the end of the plan year will be forfeited; you can roll over up to $660 from one plan year to the next for the Health Care FSA only.
- You cannot transfer money from one account to another; money in your Health Care FSA cannot be used for dependent care expenses, and money in your Dependent Care FSA cannot be used for health care expenses.
- Changes to your contribution amounts can only be changed with a qualified status change and the change being made must be consistent with the qualified event; these include birth or adoption, marriage, divorce, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse's employment, unpaid leave of absence, significant change in health coverage due to spouse's employment.
- If your employment with the Western Dakota Technical College ends, please be aware that you have 90 days from the date of termination to submit claims for eligible services incurred prior to your last day worked.
- All claims with dates of service during the plan year must be submitted to WEX by March 31, 2026. Any claim(s) submitted with a date of service after the plan deadline, or any claim(s) submitted after March 31, 2026 will be denied.

This worksheet will help you estimate medical expenses for the plan year. Do not include medical and dental premiums, spouse's after-tax group medical or dental premiums or any individual insurance premiums.

The IRS does NOT allow reimbursement for the following:

- Cosmetic Medications & Procedures
- Massage Therapy
- Lamaze/Childbirth Classes
- Health Club Memberships
- Vitamins
- Marriage/Group/Family Counseling
- Vision Service Contracts
- Insurance Premiums
- Payment of services not yet provided

Eligible Medical Expenses

This is a partial list of eligible reimbursable expenses. For a complete list refer to IRS Publications 502 & 503 http://www.irs.gov/publications/p502/index.html

Sample Medical Expenses:

- Deductibles, Co-pays & Coinsurance
- Prescription Drugs
- Annual Physicals
- Insulin/Syringes
- Hearing Exams
- Hearing Aids & Batteries
- Allergy Shots
- Fertility Treatments
- Ambulance Services
- Menstrual Products (Tampons, Pads, & Other Period Supplies)
- Alcoholism/Drug Addictions Treatment
- Psychiatric/Psychologist Fees
- Smoking Cessation Programs
- Wheelchairs/Crutches
- Vasectomy
- Laboratory Services
- Nursing Services
- Physical & Speech Therapy
- Chiropractic Treatments
- Well-Baby Care & Immunizations

Sample Dental & Vision Expenses:

- Deductibles, Co-pays & Coinsurance
- Routine Exams
- Orthodontia
- Fillings
- Bridges
- Dentures
- Crowns
- Root Canals
- Prescription Glasses & Prescription Sunglasses
- Contact Lenses
- Storage Case
- Eye Exams
- Corrective Eye Surgery
- Lens Cleaning Solutions
- Lens Enzyme Cleaners

EXPENSES	ESTIMATE
MEDICAL	
Deductibles	$
Co-Pays	$
Co-Insurance	$
Prescription Drugs	$
Insulin/Syringes	$
Menstrual Products	$
Allergy Shots	$
Annual Physicals	$
Chiropractic Treatments	$
Orthopedic Shoes (excess over cost of normal shoes)	$
Psychiatric/Psychologist Fees	$
Smoking Cessation Programs	$
Wheelchairs/Crutches	$
Hearing Exams/Aids/Batteries	$
Other	$
DENTAL	
Routine Exams	$
Fillings	$
Root Canals	$
Crowns	$
Bridges	$
Dentures	$
Orthodontia	$
Other	$
VISION	
Annual Eye Exam	$
Glasses; Second Pair	$
Prescription Sunglasses	$
Contact Lenses; Second Set	$
Contact Lens Cleaning Solution/Enzymes	$
Storage Case	$
Corrective Eye Surgery	$
Other	$
Total Annual	$
Divided by Number of Pay Periods	$
Per Pay Period Pre-tax Deduction	$

Term Life and AD&D Insurance

Insurance Carrier: The Standard
Customer Service: 800.628.8600
Website: www.thestandard.com

Base Life and Accident Death & Dismemberment

ELIGIBILITY	
Eligibility Requirement	Employee must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	There is no cost to you for this insurance.
BENEFITS	
Employee Life and AD&D Insurance Benefit Amount	$10,000. *Benefit paid may reduce due to any age reductions and/or any living care/accelerated death benefits previously paid under this plan.*
Basic Dependents Life Insurance Benefit Amount	Spouse: $2,000 Dependent Child(ren): $1,000 *Your spouse is the person to whom you are legally married under state and federal law. A dependent child means your child from live birth through age 25*

Voluntary Life and Accident Death & Dismemberment

ELIGIBILITY	
Eligibility Requirement	Employee must be actively working a minimum of 20 hours per week to be eligible for coverage.
Spouse & Dependent Child Eligibility Requirement	To be eligible for coverage, dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. *For spouse and/or child(ren) to be eligible for coverage, employee must elect coverage for themself.*

COVERAGE GUIDELINES	Minimum	Guaranteed Issue	Maximum
For You	$10,000	$250,000	Up to $500,000 *The combined maximum benefit of your basic and additional Benefit may not exceed 8 times your Annual Earnings.*
Spouse	$5,000	$50,000	Up to $250,000, not to exceed 100% of employee's benefit
Child(ren)	$10,000	$10,000	Up to $10,000, not to exceed 100% of employee's benefit

Base and Voluntary Life and AD&D Insurance will reduce to 50% of the original amount at age 70.

Supplemental Life / AD&D Rates

Monthly rates / $1,000 of coverage:

Age as of January 1st*	EE	SPOUSE
Under 24	$0.067	$0.076
25-29	$0.069	$0.076
30-34	$0.083	$0.080
35-39	$0.101	$0.087
40-44	$0.153	$0.127
45-49	$0.237	$0.188
50-54	$0.365	$0.283
55-59	$0.561	$0.422
60-64	$0.617	$0.852
65-69	$0.876	$1.581
70+	$2.592	$4.758

Rates are based on your age as of January 1st.

Calculating Your Cost

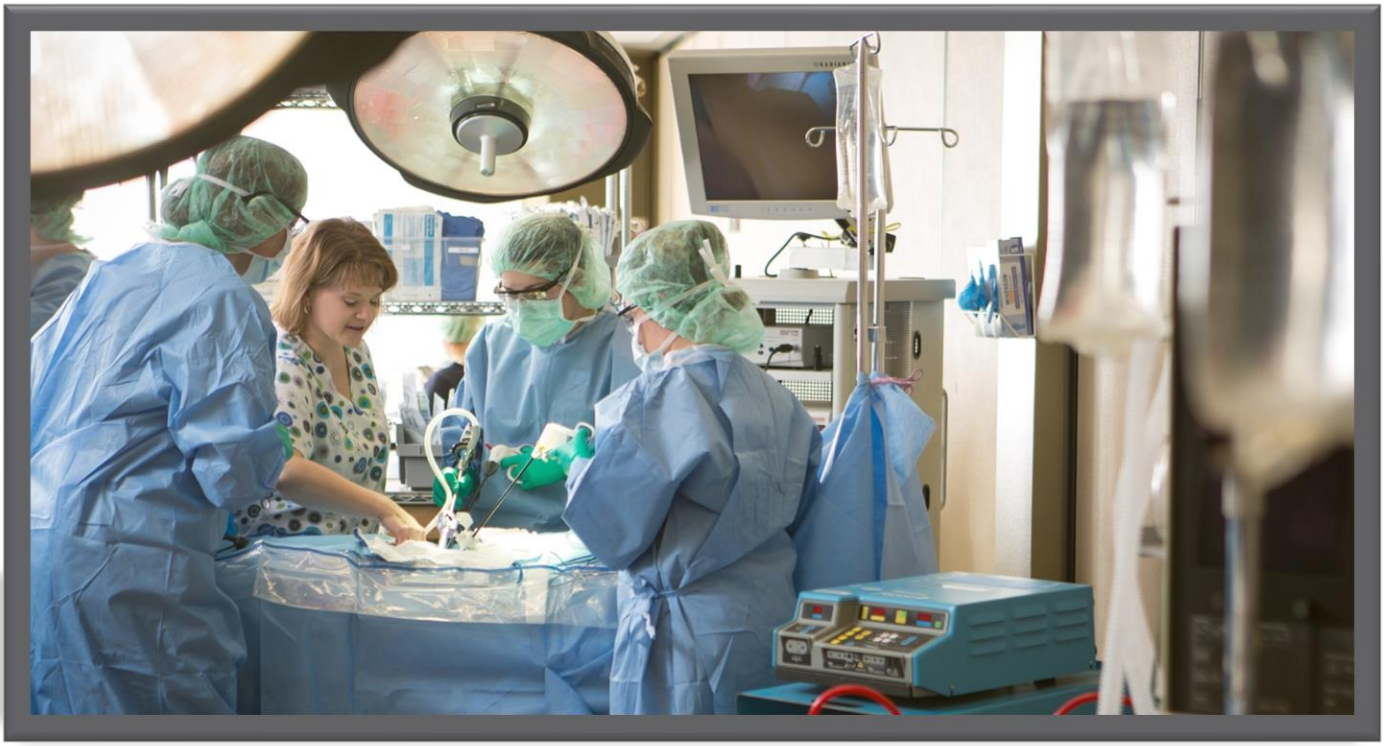
Employee: _____ (volume) X _____ (rate) / 1,000 = $ _____ Monthly Cost

Spouse*: _____ (volume) X _____ (rate) / 1,000 = $ _____ Monthly Cost

**Spouses rates are based upon his/her individual age*

Child(ren) monthly rates:

- $10,000 of coverage for $2.30 per family unit



Voluntary Short-term Disability Insurance

Insurance Carrier: The Standard
Customer Service: 800.368.1135
Website: www.standard.com

Western Dakota Technical College offers benefit eligible employees the opportunity to purchase Short-term Disability benefits through The Standard. Disability coverage provides income replacement if you are unable to work because of a covered illness or injury.

Coverage	Elimination Period*	Benefit Amount	Benefit Duration
Short-term Disability	14-days Accident & 14-days Illness	60% of your pre-disability earnings up to $2,000 per week	Up to 90-days

Definition of Disability and Disabled: *You will be considered Disabled if, solely and directly because of sickness, injury, or pregnancy, one of the following applies:*

a) You cannot perform the majority of the Substantial and Material Duties of your Own Job.

b) You are performing the duties of your Own Job on a Modified Basis or any job and are unable to earn more than 80% of your Pre-disability Earnings:

The loss of a professional or occupational license or certification does not, in itself, constitute a Disability.

HOW TO CALCULATE YOUR SHORT-TERM DISABILITY COST	
Determine your Weekly Benefit	Annual Salary / 52 * 0.6 = Weekly Benefit *(Weekly benefit cannot exceed more than $2,000)*
Calculate your Per Month Short-term Disability cost	Weekly Benefit / $10 * Rate (table below) = Per Month Cost *(To get your per paycheck cost, divide the per month cost by 2)*
Example Calculation	$519.23 (weekly benefit) / 10 * $0.40 (Age 42) = $20.77 per month *(Per paycheck amount: $20.77 / 2 = $10.39 per check)*

Age as of January 1st*	Per Month Rate
< 29	$0.775
30 – 34	$0.830
35 – 39	$0.497
40 – 44	$0.338

Age as of January 1st*	Per Month Rate
45 – 49	$0.359
50 – 54	$0.386
55 – 59	$0.502
60+	$0.633

Rates are based on your age as of January 1st.

Employee Assistance Program

Insurance Carrier: Health Advocate
Phone: 888.293.6948
Website: www.workhealthlife.com/Standard3

A benefit for you and your family

The HealthAdvocate employee assistance program (EAP) is a problem-solving resource available to you and eligible members of your family. A professional counselor will help you assess your situation, identify options, make choices, and get additional help. When life happens, we're here.

It's Free

The initial assessment, the problem-solving sessions, and the referral services are all covered. If more counseling or treatment is needed, your counselor will help you figure out your options.

It's Confidential

Your EAP is set up with an outside counseling resource to ensure confidentiality. No one at work knows anything beyond what you choose to tell them. Nothing about your use of EAP appears in your employee personnel file.

It's Convenient

Your EAP is as close as your phone. Our confidential intake process sets up face-to-face sessions with a licensed counselor near your work or home. Phone counseling services are also available.

They are here to help

Your employee assistance program (EAP) provides free and confidential professional consulting, coaching, and counseling services for these and many other challenges:

- Chemical dependency
- Conflict resolution
- Coping with stress
- Depression, anxiety, and other mental health challenges
- Eldercare or childcare
- Financial troubles
- Grief and loss or change
- Legal concerns
- Parenting support
- Relationship concerns
- Work or career concerns

Online Resources

HealthAdvocate offers a wide range of information and resources that you can research and access on your own just by visiting GuidanceResources.com. You'll find:

- Articles and tutorials
- Streaming videos
- Self-Assessments
- Links, and
- Webinars.

Contact *HealthAdvocate*[SM] EAP 24 Hours/365 Days

Voluntary Accident Insurance

Insurance Carrier: The Standard
Customer Service: 800.634.1743 (7 a.m. through 6 p.m. Mountain)
Website: www.standard.com

Common injuries like major cuts, fractures or dislocations can result in hundreds of dollars in out-of-pocket medical expenses and time missed from work. The Standard's Accident Insurance includes benefits for initial care (ambulance, ER, Doctor's Office Visit, etc.), hospitalization, follow up care plus Accidental Death & Dismemberment Benefits.

How it works

Accident insurance provides benefits to help cover out-of-pocket medical expenses related to an accidental injury.

Benefits are paid based on the type of injury or service performed and do not interfere or coordinate with your major medical plan.

Why accident insurance?

Understanding how accident insurance fits into your overall benefits package can help you decide if it's right for you and your family.

Consider your health care out-of-pocket liability. Accident insurance can help you reach your deductible, copay or coinsurance requirements while paying little to nothing from your own pocket.

Accident insurance benefits can also be used to pay for additional costs triggered by an accident, such as childcare or transportation during recovery.

What's Covered?

Accident Insurance helps pay for the following after an accidental injury:

Emergency care and diagnostics

Benefits are provided for eligible expenses incurred during initial care and testing procedures.

Examples: Ambulance rides, emergency room admission, X-rays

Hospitalization and surgeries

Benefits are provided for eligible expenses incurred while hospitalized or undergoing a surgical procedure.

Examples: Hospital admission, ICU, surgery, rehabilitation

Follow-up care

Benefits are provided for eligible expenses incurred while receiving follow-up care or equipment after an accidental injury.

Examples: Physical therapy, chiropractic visits, medical equipment, prosthetic devices

Common injuries

Benefits are provided for eligible expenses incurred while treating accidental injuries considered common.

Examples: Fractures, dislocations, second- and third-degree burns, eye injuries

Benefits are paid regardless of any other coverage you have under your major medical or other health insurance policy.

Voluntary Accident Insurance (Continued)

Claims Example

Mike has an active lifestyle, so he knew that enrolling in his company's accident insurance was the right decision. Shortly after enrolling, Mike breaks his leg on a hiking trip with his friends. After a trip to the emergency room, Mike's thankful he has accident insurance to help with his out-of-pocket costs.

Here's an example of the benefits Mike would receive if he had enrolled in the Low or High plan of his company's accident insurance:

Treatment / Services	Accident Plan Benefit Payments
Emergency room visit	$150
X-ray	$50
Treatment for leg fracture (closed)	$1,200
Three physical therapy sessions	$150 ($50 per visit)
Total	**$1,550**

Because Mike has accident insurance, he now has funds to help pay for:

- Medical expenses
- Other related costs such as:
  - Childcare during recovery
  - Transportation to physical therapy sessions
- Any other expenses, medical-related or not

You, and each covered member under your accident plan, can get a Health Maintenance Screening Benefit of $50 each year just for going to the doctor for a covered screening, such as a mammography, colonoscopy, stress test or lipid panel.

The $50 benefit will be issued in the form of a check and mailed directly to your address.

Cost of Coverage:

Coverage Type	Monthly Premium
Employee Only	**$7.63**
Employee + Spouse	**$12.45**
Employee + Children	**$14.91**
Employee + Spouse and Children	**$23.37**

Voluntary Critical Illness Insurance

Insurance Carrier: The Standard
Customer Service: 800.634.1743 (7 a.m. through 6 p.m. Mountain)
Website: www.standard.com

The Standard's voluntary critical illness insurance provides a lump sum payment if a covered condition is diagnosed after coverage takes effect for the individual. Covered conditions include critical illnesses and/or conditions, as specified below.

Critical Illness Insurance Benefit Options	
Employee	**$10,000, $20,000 or $30,000** *Coverage is guaranteed provided you are actively at work.*
Spouse	**50% of the employee's coverage amount** *Coverage is guaranteed provided the employee is actively at work and the spouse is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.*
Dependent Child(ren)	**25% of the employee's coverage amount** *Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.*

Critical Illness Insurance Coverage Details	
Core Benefits	Cancer: 100%, Cancer in Situ: 25%, Heart Attack: 100%, Stroke: 100%, Severe Coronary Artery Disease with a Recommendation of Bypass Surgery: 25%, Major Organ Failure: 100%, Occupational Hepatitis: 100%, Occupational HIV: 100%, End-Stage Renal Failure: 100%, Loss of Sight: 100%, Loss of Speech: 100%, Loss of Hearing: 100%, Paralysis (2 or more limbs): 100%, Bone Marrow Transplant: 100%
Neurological Conditions	Amyotrophic Lateral Sclerosis (ALS): 100%, Advanced Alzheimer's: 100%, Advanced Parkinson's Disease: 100%, Advanced Multiple Sclerosis: 100%, Coma: 100%, Benign Brain Tumor: 100%
Childhood Conditions	21 different childhood conditions covered. See policy for more information.

Critical Illness Insurance Additional Benefits (not an all-inclusive list)	
Health Screening Benefit	Pays an annual benefit amount of $50 for any covered health maintenance screening procedure incurred by the employee, spouse, or child.
Additional Occurrences	If you are diagnosed with a Covered Critical Illness, and you are then, at least one day later, diagnosed with a different Covered Critical Illness, we will also pay the additional Critical Illness benefit for the second covered condition.
Reoccurrence Benefit	Pays an additional benefit of 100% of the critical illness benefit when a specific critical illness recurs more than 6 month(s) after the first diagnosis. Each condition is payable an unlimited number of times unless otherwise specified in the certificate.
Lifetime Maximum Benefit Payout	No lifetime maximum on benefits paid.

Voluntary Critical Illness Insurance (Continued)

Monthly Premiums

Cost is dependent upon how much coverage is selected and the age of the insured as of the effective date. Because attained age rating applies, premiums may increase due to age changes upon the start of the next policy year.

EMPLOYEE MONTHLY RATES: NON-TOBACCO

Employee Age	$10,000	$20,000	$30,000
29 & under	$3.10	$6.20	$9.30
30 – 39	$4.60	$9.20	$13.80
40 – 49	$9.00	$18.00	$27.00
50 – 59	$18.20	$36.40	$54.60
60 – 69	$32.40	$64.80	$97.20
70 – 80	$64.30	$128.60	$192.90

EMPLOYEE MONTHLY RATES: TOBACCO

Employee Age	$10,000	$20,000	$30,000
29 & under	$3.20	$6.40	$9.60
30 – 39	$5.40	$10.80	$16.20
40 – 49	$13.30	$26.60	$39.90
50 – 59	$32.20	$64.40	$96.60
60 – 69	$65.50	$131.00	$196.50
70 – 80	$124.70	$249.40	$374.10

SPOUSE MONTHLY RATES: NON-TOBACCO

Spouse Age	$5,000	$10,000	$15,000
29 & under	$1.55	$3.10	$4.65
30 – 39	$2.30	$4.60	$6.90
40 – 49	$4.50	$9.00	$13.50
50 – 59	$9.10	$18.20	$27.30
60 – 69	$16.20	$32.40	$48.60
70 – 80	$32.15	$64.30	$96.45

SPOUSE MOTHLY RATES: TOBACCO

Spouse Age	$5,000	$10,000	$15,000
29 & under	$1.60	$3.20	$4.80
30 – 39	$2.70	$5.40	$8.10
40 – 49	$6.65	$13.30	$19.95
50 – 59	$16.10	$32.20	$48.30
60 – 69	$32.75	$65.51	$98.26
70 – 80	$62.35	$124.70	$187.05

Important Notices

Important Notices & Documents

Federal regulations require Western Dakota Technical College to provide benefit eligible employees with important notices and documents. For a full copy of any of these notices and documents, please go to the Business Office. Notices and documents may include, but are not limited to:

Summary Plan Description (SPD) Access

This guide does not provide all the details about the benefits programs. More information is available in each program's Summary Plan Description (SPD). In addition to receiving your SPDs after enrolling, they are available at any time from the Business Office.

Notice of Special Enrollment Rights

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

Loss of Other Coverage

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

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator.

HIPAA Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides you certain rights to privacy concerning your health information. The regulations designate certain types of information as Protected Health Information (PHI).

Healthcare providers (medical professionals) and health plans, including Western Dakota Technical College health plan representatives, are restricted in their use of PHI to purposes of treatment, payment, and healthcare operations and as required by national public health activities. Written authorization is required to use or disclose your PHI pertaining to your medical, dental, prescription drug, employee assistance program and healthcare spending accounts outside of these purposes.

You may receive a form requesting your authorization to use your PHI for another purpose. Should you grant this authorization, your PHI is still protected from use and disclosure by any party other than the one(s) to whom you grant written authorization, and from use and disclosure by authorized parties for any purpose other than the one you specifically authorized.

Protected Health Information

PHI includes information that could be used to identify you as an individual in electronic, printed or spoken forms that relates to (1) past, present or future health, physical or mental condition, (2) provision of healthcare, or (3) past, present or future payment for the provision of healthcare.

HIPAA gives you the right to:

Receive notice of the health plan's uses and disclosures of your PHI, your privacy rights and the health plan's legal duties regarding your PHI; Obtain access to your own PHI; Amend your PHI; Request restriction of the uses and disclosures of your PHI; Receive an accounting of nonexempt uses and disclosures of your PHI over the past six years upon request; and Receive communications by an alternative means or at an alternate location upon request.

For more information regarding the HIPAA privacy rules, refer to your Summary Plan Description.

HIPAA Privacy Notice Update

HIPAA requires Western Dakota Technical College to notify you that a Privacy Notice is available from the Business Office. To request a copy of Western Dakota Technical College Privacy Notice or for additional information, please contact the Business Office.

Privacy Notice or for additional information, please contact the Western Dakota Technical College Business Office.

Genetic Information Nondiscrimination Act (GINA)

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

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member, or an embryo lawfully held by a member receive assistive reproductive services.

Mental Heath Parity & Addiction Act (MHPAEA)

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

Newborns and Mothers Health Protection Act Rights

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

Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site:
http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit http://www.dol.gov/vets.
For an interactive online USERRA Advisor, you can visit http://www.dol.gov/elaws/userra.htm

Medicaid and the Children's Health 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).**

For more information on special enrollment rights, you can contact:

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
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 https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	**Kansas – Medicaid** Website: https://www.kancare.ks.gov/ 1-800-792-4884 HIPP Phone: 1-800-967-4660
North Carolina – Medicaid https://medicaid.ncdhhs.gov/ 919-855-4100	**South Dakota – Medicaid** http://dss.sd.gov 1-888-828-0059
Washington – Medicaid https://www.hca.wa.gov/ 1-800-562-3022	**Wyoming – Medicaid** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 1-800-251-1269

Important Notice from Western Dakota Technical College 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 Western Dakota Technical College 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. Wellmark BCBS of South Dakota has determined that the prescription drug coverage offered by the Western Dakota Technical College 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 Western Dakota Technical College coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Western Dakota Technical College coverage, be aware that you and your dependents may not 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 Western Dakota Technical College 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 at 605-718-2402. 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 Western Dakota Technical College 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: 5/1/2025

Name of Entity/Sender:	Human Resource Office, Western Dakota Technical College
Contact—Position/Office:	Julie Penney, Sr. Human Resources Generalist
Address:	800 Mickelson Drive, Rapid City, SD 57703
Phone Number:	605-718-2407 or via email at Julie.Penney@WDTC.edu

Employee Rights Under the Family Medical Leave Act

Leave Entitlements	Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons: • The birth of a child or placement of a child for adoption or foster care; or, • To bond with a child (leave must be taken within one year of the child's birth or placement); or, • To care for the employee's spouse, child, or parent who has a qualifying serious health condition; or, • For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job; or, • For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent. An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.
Benefits & Protections	While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.
Eligibility Requirements	An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must: • Have worked for the employer for at least 12 months; and, • Have at least 1,250 hours of service in the 12 months before taking leave;* and, • Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.
Requesting Leave	Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.
Employer Responsibilities	Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.
Enforcement	Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.
Contact Info.	For additional information or to file a complaint: 1-866-4-USWAGE (www.dol.gov/whd).

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name **Western Dakota Technical College**		4. Employer Identification Number (EIN) **86-2647921**
5. Employer Address **800 Mickelson Drive**		6. Employer Phone Number **605-718-2407 or 605-718-2408**
7. City **Rapid City**	8. State **SD**	9. Zip Code **57003**
10. Who can we contact at this job? **Human Resources**		
11. Phone number (if different from above) **605-718-2407 or 605-718-2408**	12. Email address **wdthumanresources@wdt.edu**	

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

- ✓ As your employer, we offer a health plan to:
  - ✓ All employees. Eligible employees are:

    Employees who are employed in permanent positions that require 20 or more hours of work per week, or 86 hours a month on average. Employees who are employed in temporary positions that require 30 or more hours of work per week, or 130 hours a month, on average, are eligible for benefits.

  - ☐ Some employees. Eligible employees are:

- ✓ With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are:

    Legal spouse, natural child(ren), legally adopted children, any child(ren) placed in your home for adoption, stepchild(ren), legally appointed foster child(ren), and child(ren) for whom you are responsible under court order, and children for whom you are appointed legal guardianship.

  - ☐ We do not offer coverage.

- ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Contact Information

Benefit	Vendor	Contact Information
Medical	Wellmark EBS	800.831.4818 www.mywellmark.com 601.353.0002 www.ebsincservices.com
Dental	DELTA DENTAL	605.224.7345 www.deltadentalsd.com
Flexible Spending Accounts	wex	866.451.3399 https://benefitslogin.wexhealth.com
Base Life / AD&D **Supplemental Life**	TheStandard	800.628.8600 www.standard.com
Short-term Disability	TheStandard	800.368.1135 www.standard.com
Critical Illness **Accident Insurance**	TheStandard	800.634.1743 www.standard.com
Employee Assistance Program	TheStandard	888.293.6948 www.healthadvocate.com/standard3

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