

Employee Benefits Overview



Below are outlines of the Medical, Dental, and Vision benefits offered to employees of USD Rose Hill Schools as well as contact information for all plans, effective 10/1/2026.

Please refer to the Plan Documents for full details on these benefits, which can be found at www.brainshark.com/gallahgher/usd394rosehill_2026 or can scan the QR code.



To Enroll go to: <https://identity.arcoro.com/Account/Login>

Aetna Medical Plans	Option 1 – OPEN \$2,500	Option 2 – OPEN \$5,000 Option 3 - WESLEY \$5,000	Option 4 – WESLEY \$6,500
	In-Network	In-Network	In-Network
Primary Care Physician Office Visit	\$30 Copay	\$5 Copay	\$20 Copay
Specialty Care Physician Office Visit	\$70 Copay	\$65 Copay AFTER DEDUCTIBLE	\$65 Copay AFTER DEDUCTIBLE
Preventive Services Eye Exam (1 exam per 12 months)	100% as required by Health Care Reform 100% Covered	100% as required by Health Care Reform 100% Covered	100% as required by Health Care Reform 100% Covered
Inpatient and Outpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	\$250 Copay + Deductible & Coinsurance	\$200 Copay + Deductible & Coinsurance	\$300 Copay + Deductible & Coinsurance
Mental Health	Inpatient: Deductible & Coinsurance Outpatient: \$70 Copay	Inpatient: Deductible & Coinsurance Outpatient: \$65 Copay	Inpatient: Deductible & Coinsurance Outpatient: \$65 Copay
ANNUAL DEDUCTIBLE	Annual Deductible	Annual Deductible	Annual Deductible
Individual	\$2,500	\$5,000	\$6,500
Family	\$5,000	\$10,000	\$13,000
MAXIMUM OUT-OF-POCKET	Maximum Out-of-Pocket	Maximum Out-of-Pocket	Maximum Out-of-Pocket
Individual	\$4,000	\$6,850	\$9,100
Family	\$8,000	\$13,700	\$18,200
Retail Prescription Drugs Value Drugs Tier 1A Preferred Generic Preferred Brand - Name Drugs Non - Preferred Generic/Brand Specialty Drugs Preferred Non-Preferred	\$3 Copay \$10 Copay \$45 Copay \$70 Copay 20% up to max \$150 Copay 20% up to max \$250 Copay	\$3 Copay \$12 Copay \$50 Copay AFTER DEDUCTIBLE \$75 Copay AFTER DEDUCTIBLE 20% up to max \$150 Copay 20% up to max \$250 Copay	\$3 Copay \$12 Copay \$50 Copay AFTER DEDUCTIBLE \$75 Copay AFTER DEDUCTIBLE 20% up to max \$150 Copay 20% up to max \$250 Copay

Note: If you select Option 4 - WESLEY PREFERRED \$6,500 Plan, you will be required to designate a Primary Care Physician (PCP) and enter their Aetna PROVIDER ID # when you complete your online enrollment. You will be required to do this for everyone covered on the plan. You can access the contracting provider list for this plan by following the directions on page 8 in Enrollment Guide.

Note: Nurse Practitioners and Physician Assistants cannot be designated as a Primary Care Provider. You will need to list the physician in which they practice under.

Aetna Employee Deduction	Option 1 OPEN \$2,500		Option 2 OPEN \$5,000		Option 3 WESLEY \$5,000		Option 4 WESLEY \$6,500	
	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY
Employee Only	\$512.29	\$256.15	\$241.23	\$120.62	\$198.06	\$99.03	\$68.12	\$34.06
Employee + Spouse	\$1,595.90	\$797.95	\$1,013.15	\$506.58	\$920.32	\$460.16	\$640.95	\$320.48
Employee + Child(ren)	\$1,313.18	\$656.59	\$811.75	\$405.88	\$731.88	\$365.94	\$491.50	\$245.75
Employee + Family	\$2,161.25	\$1,080.63	\$1,415.86	\$707.93	\$1,297.14	\$648.57	\$939.82	\$469.91

Delta Dental of Kansas	PPO Premier Network
Preventive	100%
Basic	80% after deductible
Major	50% after deductible
Orthodontics (For children up to age 19)	50% up to lifetime maximum of \$1,000
Annual Deductible	\$25/person, \$75/family
Annual Maximum Benefit	\$1,500 per person

Delta Employee Deduction	Dental	
	MONTHLY	SEMI-MONTHLY
Employee Only	\$36.22	\$18.11
Employee + Spouse	\$71.70	\$35.85
Employee + Child(ren)	\$70.74	\$35.37
Employee + Family	\$120.24	\$60.12

Surency Option 1 Comprehensive	EyeMed Insight Network	Employee Deduction		
Annual Copay for Exams	\$10	Comprehensive Vision Plan Option 1		
Exam 1 Every 12 Months	100% Benefit	Vision Deductions	MONTHLY	SEMI-MONTHLY
Annual Copay for Materials	\$25	Employee Only	\$10.38	\$5.19
Lenses Every 12 Months	100%	Employee + Spouse	\$21.83	\$10.92
Frames Every 24 Months	Up to \$130	Employee + Child(ren)	\$18.69	\$9.35
Contacts Every 12 Months	In Lieu of glasses 100% up to \$130	Employee + Family	\$35.01	\$17.51

Surency Option 2 Materials Only	EyeMed Insight Network
Annual Copay for Exams	N/A
Exam 1 Every 12 Months	N/A
Annual Copay for Materials	N/A
Lenses Every 12 Months	N/A
Frames Every 24 Months	Up to \$200
Contacts Every 12 Months	In Lieu of glasses 100% up to \$130

Employee Deduction		
Materials Only Vision Plan -Option 2		
Vision Deductions	MONTHLY	SEMI-MONTHLY
Employee Only	\$9.57	\$4.79
Employee + Spouse	\$20.07	\$10.04
Employee + Child(ren)	\$17.21	\$8.61
Employee + Family	\$33.45	\$16.73

Guardian		
LIFE and AD&D; VOLUNTARY LIFE and AD&D; SHORT TERM DISABILITY		Employee Deduction
Life/AD&D	Employees: \$10,000; Principals & Directors: \$50,000; Superintendent & Assistant Superintendent: \$100,000.	100% Paid by USD 394 Rose Hill
Voluntary Employee Life and AD&D	\$10,000 increments to \$500,000 - not to exceed 5x salary. Guarantee Issued: \$130,000 or 5 times your annual salary.	Rates are listed in Arcoro and in your Guide, page 20 & 21
Voluntary Spouse Life and AD&D	\$5,000 increments to \$250,000 - not to exceed 100% of EE's. Guarantee Issue: up to \$50,000 - not to exceed 100% of EE's.	Rates are listed in Arcoro and in your Guide, page 20 & 21
Voluntary Child Life	14 days to age 20 or to age 25 for full-time students: \$10,000.	\$2.00 monthly & \$1.00 Semi-monthly
Short-Term Disability	Option 1: 60% of weekly salary; max of \$1,000 per week. Paid on the 15th day for up to 24 weeks.	\$0.53 Monthly and \$0.27 Semi-Monthly
	Option 2: 60% of weekly salary; max of \$1,000 per week. Paid on 60th day up to 17 weeks.	\$0.25 Monthly and \$0.13 Semi-Monthly
3 in 1 includes: ACCIDENT; CRITICAL ILLNESS; HOSPITAL INDEMNITY		Employee Deduction
Accident	Accident ER; Ambulance; Dislocation; Eye Injury; Fractures; Hospital Admissions; Laceration; X-Ray, full list of Accidents are listed in your guide.	3 in 1 Deductions
		MONTHLY SEMI-MONTHLY
Critical Illness	\$5,000 Employee; \$5,000 Spouse; \$2,500 Child(ren). Cancer; Heart Attack; Stroke; Heart Failure, full list of Critical Illness conditions are listed in your guide.	Employee Only
		\$29.40 \$14.70
Hospital Indemnity	Hospital Admission: \$1,000 to a max of 1 admission per year. Hospital Confinement \$100 per day to a max of 15 days.	Employee + Spouse
		\$58.30 \$29.15
		Employee + Child(ren)
		\$44.16 \$22.08
		Employee + Family
		\$73.75 \$36.88

Carrier Contact Information

LegalShield IDShield	Family Monthly	Individual Monthly
LegalShield	\$18.95	\$16.95
IDShield	\$18.95	\$8.95
Combined	\$33.90	\$25.90
Gun Owners Supplement		
\$12.95 when purchased with Legal plan Covers Employee & Spouse/Partner		

Benefit Plan	Carrier	Phone	Website
Medical	Aetna	800.445.5299	www.aetna.com
Dental	Delta Dental of Kansas	800.234.3375	www.deltadentalks.com/Su bscribers
Vision	Surency Vision	866.818.8805	www.surency.com/Members /SurencyVision/
Life / AD&D / Voluntary Life	Guardian	888.482.7342	www.guardianlife.com
STD	Guardian	888.482.7342	www.guardianlife.com
Accident/Critical Illness/Hospital Indemnity	Guardian	888.482.7342	www.guardianlife.com
LegalShield/IDShield	LegalShield/IDShield	316.215.5100	www.bobpilcher.com