2022

ATCHISON PUBLIC SCHOOLS BENEFITS GUIDE

Building Successful Futures: Every Student, Every Day

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2022 BENEFITS OVERVIEW

Welcome to the 2022 Benefits Open Enrollment

Atchison Public School's annual benefits open enrollment period is about to begin.

Enroll online at
www.benefits-direct.com/atchisonusd/

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Prior to open enrollment, you can prepare by doing the following:

Check out the plans being offered for the coming year

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the Atchison Public Schools family and look forward to a healthy and safe 2022.

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

IMPORTANT DATES

Open enrollment runs

MAY 16, 2022 —

MAY 20, 2022

2022 HIGHLIGHTS AT A GLANCE

- **Medical**
  - The medical Insurance carrier will continue to be with Blue Cross Blue Shield of Kansas (BCBSKS)
  - You will continue to the have the three medical plan options to choose from.
  - **NEW! Mandatory Generic Program:** BCBSKS is implementing a Mandatory Generic program effective 7/1/22. This means that you will have to get a generic drug filled if there is one available unless your doctor provides you with an override to get the name brand. If you don't obtain the override from your doctor you will have to pay the brand copay plus the cost difference between the generic and brand name drug. ***See page 9 for more Pharmacy Updates.***
- **Vision and Dental** plans will renew with no change in benefits. The vision premiums will remain the same and there is slight increase to the dental premiums.
- **Health Savings Account** maximum will be increasing to $3,650 for single coverage and $7,300 for family coverage
- **Health Care FSA** maximum contribution will be increasing to $2,850

CONTACT INFORMATION

Medical
Blue Cross Blue Shield of Kansas
Group # 09161
www.bcbsks.com
800.432.3990

Dental
Delta Dental of Kansas
Group # 52765
www.deltadentaltalks.com
800.234.3375

Vision
Superior Vision
Group # 29248
www.superiorvision.com
800.507.3800

Health Savings Accounts
UMB Bank
www.hsa.umb.com
866.520.4472

Flexible Spending Accounts
ASI Flex
www.asiflex.com
800.659.3035

Voluntary Life and AD&D, Dependent Life
Reliance Standard
Group #VG183750
www.reliancestandard.com
844.658.0121

Short-Term Disability
Reliance Standard
Group # VPS326279
www.reliancestandard.com
844.658.0121

Permanent Life with Long Term Care
Trustmark Insurance
www.trustmarkbenefits.com
844.658.0121

Critical Illness and Cancer Insurance
Prosperity
844.658.0121

Hospital Indemnity
Reliance Standard
844.658.0121

Identity Protection
IdentityForce
Group # 2121
844.858.9581

Legal Services
MetLife Legal
Group # 094/0011
www.legalplans.com
800.821.6400 or 844.658.0121

Atchison Public Schools Business Manager
Lori Lanter
llanter@usd409.net
913.370.5889

Enrollment Platform and Voluntary Products
AmeriLife Benefits-Benefits Direct
www.benefits-direct.com/atchisonusd/
844.658.0121

HOW TO ENROLL

Atchison Public Schools Open Enrollment Period will be held from **5/16/22 TO 5/20/22.** You make elections through Amerilife-BenefitsDirect during this period with one of the following options: **(1) Self-enrollment or (2) Call Center/Virtual Meeting with a Benefit Counselor.**

All eligible employees are required to complete enrollment by either electing or waiving benefits.

- SELF ENROLLMENT
- CALL CENTER MEETING

SELF-ENROLLMENT:

- Use this website to self-enroll in your 2022-2023 benefits www.benefits-direct.com/atchisonusd/.
- Enroll: When on the webpage, use the "**How to Enroll**" tab at top of page to elect "**Self-Enroll Now**" for your 2022-2023 benefits.
- All User names and passwords have been reset for Open Enrollment.

  User ID: 1st initial of your first name + last name + the last 4 digits of your social security number (SSN)

  Example: John Smith SSN 123-54-1453

  User ID: jsmith1453 (do not use dashes or spaces)

  Personal Identification Number (PIN): Last four of SSN + last two digits of birth year

  Example: Date of Birth March 16, 1960

  PIN: 145360
- Once you have successfully logged into the system, it will guide you through each step of the process by clicking "**Next**" in the bottom right hand corner of each screen.
- Enrollment is not complete until you sign confirmation and see **"Congratulations"** you have completed your enrollment.
- Self-Enroll Instructions are posted on the Home Page of the Employee Portal at www.benefits-direct.com/atchisonusd/ under the "**How To Enroll**" tab drop down and select "**Self Enroll Instructions**."
- **Self-Enrollment is available May 16th - May 20th.**
- Contact AmeriLife-BenefitsDirect Customer Service at 844.658.0121, option 1, if you need assistance.

CALL CENTER MEETING WITH A BENEFIT COUNSELOR:

Virtual meetings are available for those who prefer and have access to their laptop, iPad, or other electronic devices during their scheduled meeting time.

- Appointments are required if you want to complete your enrollment with a benefit counselor.
- Book an appointment with a counselor by using the Employee Portal website www.benefits-direct.com/atchisonusd/and use the **"How To Enroll"** tab drop down and select **"Book Appointment."**
- The "**Book Appointment"** button will be available beginning **Wednesday, May 11th.**
- After clicking "Book Appointment" select the day and time you would like. Please provide Complete Name, Email, and Phone Number (include Area Code). Please provide the number of where you can be reached on your selected day and time by the Benefit Counselor as they will be calling you. ***Please note: The call could be up to 10 minutes after your scheduled time.***
- You may schedule a Call Center appointment with a benefit counselor **Monday, May 16th through Friday, May 20th.**

CALL CENTER:

- The call center is open Monday - Friday 8am-5pm CST.
- If you are needing a password reset or help with the system contact **844-658-0121 option 1.**
- If you have questions regarding products as you are Self-Enrolling contact **844.658.0121, option 2.**

Remember: You cannot adjust your annual elections unless you have a qualifying life event such as marriage, birth, adoption, etc. Please visit the Benefits Department to determine if your situation qualifies as a change in status.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As an employee of Atchison Public Schools you have the choice between three medical plan options: the $1500 Deductible Plan, the $2500 Deductible Plan and the QHDHP (Qualified High-Deductible Health Plan).

For each plan, your deductible will run from July 1 - June 30.

While all three plans give you the option of using out-of-network providers, you can save money by using in-network providers because BCBSKS has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and BCBSKS UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

The QHDHP offers you significantly lower premiums than the $1500 Deductible and $2500 Deductible plans and you can establish a Health Savings Account (HSA) with the bank of your choice and contribute all or part of the premium savings into the HSA. These funds can be used to cover medical expenses, including deductibles, and they're yours forever—even if you leave Atchison Public Schools. And unlike a Flexible Spending Account (FSA), they are not forfeited at the end of each year.

QHDHP PLANS OFFER SEVERAL BENEFITS:

- Lower premium contributions
- Routine preventive exams are covered at 100%
- The HSA is owned by you
- You have more control over your health care dollars

PPO PLANS MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You do not wish to establish a Health Savings Account
- You would rather know the set monthly copays and pay less on medical expenses when they occur
- You expect to incur medical expenses at the beginning of the year

Get the most out of your insurance by using in-network providers.

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1: $1500 Deductible Plan**
- ☐ **OPTION 2: $2500 Deductible Plan**
- ☐ **OPTION 3: Qualified High Deductible Health Plan**

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must work a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

You will only receive a new medical ID card if you change plans.

? Does the deductible run on a calendar year or policy year basis?

A contract year basis. July 1 - June 30.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

MEDICAL PLAN OPTIONS

BCBSKS	PLAN OPTION 1: Buy-up - $1500 PPO	PLAN OPTION 2: Core - $2500 PPO	PLAN OPTION 3: $5000 Qualified High Deductible Health Plan
	Employee Cost Per Pay Period		
Employee Only Employee & Spouse Employee & Child(ren) Employee & Family	$107.03 $861.45 $780.30 $1,534.71	$73.69 $789.75 $712.73 $1,428.80	$0.00 $631.31 $563.41 $1,194.73
	In-Network[1]	In-Network[1]	In-Network[1]
Deductible Individual Family	$1,500 $3,000	$2,500 $5,000	$5,000 $10,000
Coinsurance *(Member Pays)*	20%	20%	0%
Out-of-Pocket Maximum Individual Family *(includes deductible, coinsurance & copays)*	$5,000 $10,000	$6,350 $12,700	$6,350 $12,700
Office Visit Primary Care Physician / Specialist	$35 copay $70 copay	$35 copay $70 copay	Deductible Deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Diagnostics Lab and X-ray Major Diagnostics *(MRI, CT, PET…)*	First $300 paid at 100%, then 20% after deductible	First $300 paid at 100%, then 20% after deductible	Deductible Deductible
Urgent Care	$35 copay (if PCP)	$35 copay (if PCP)	Deductible
Emergency Room	Deductible then 20% after $250 copay	Deductible then 20% after $250 copay	In-Network deductible
Outpatient Surgery	20% after deductible	20% after deductible	Deductible
Inpatient Hospital Services	20% after deductible	20% after deductible	Deductible
NEW! MANDATORY GENERIC PROGRAM! (SEE PAGE 9 FOR MORE DETAILS) **Prescription Drug** Retail *(at participating pharmacies)*	$15 Generic/$50 Preferred/$75 Non-Preferred/$150 for Specialty/20% up to $250 for Non-preferred Specialty	$15 Generic/$50 Preferred/ $75 Non-Preferred/$150 for Specialty/ 20% up to $250 for Non-preferred Specialty	Medical Deductible then: $15 Generic/$50 Preferred/ $75 Non-Preferred/$150 for Specialty/ 20% up to $250 for Non-preferred Specialty
Mail Order *(90-day supply)*	2.5x	2.5x	2.5x

All plans are detailed in BCBSKS 2022 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

[1]Your financial responsibility is based on your provider's network:

In-network: PPO (Blue Choice) or Traditional (CAP). Maximum benefits are available when services are received from Blue Choice providers.

Out-of-Network: Non-Blue Choice & Non-CAP: The difference between the payment allowance and provider charge, additional 20% non-PPO network coinsurance amount*, deductible, coinsurance or copay amount. CAP (Non-Blue Choice): Additional 20% non-PPO network coinsurance amount*, deductible, coinsurance or copay amount. Blue Choice: Deductible, coinsurance or copay amount.
*Non-PPO Coinsurance limited to a combined $2,000 per person, $4,000 two-or more persons each benefit period.

PRESCRIPTION DRUG PROGRAM

Blue Cross Blue Shield of Kansas reviews and updates its Prescription Drug List (PDL) periodically. The list of preferred medication is subject to change throughout the year. Members can obtain the most accurate prescription drug coverage information by selecting the BCBSKS ResultsRx Medication List at bcbsks.com/drugs.

Prescription Coverage Tiers and Costs:

Tiers are the different cost levels you pay for a medication. Under the QHDHP plan, the cost of your prescription is applied to your deductible/out-of-pocket maximum. If you reach the out-of-pocket maximum, your costs will be covered at 100%.

NEW! MANDADATORY GENERIC PROGRAM: Generic Mandatory – Generic medications are mandatory unless the prescription practitioner has provided the override to receive the brand name drug. If the member does not have the doctor override, the member is responsible for any cost difference above the copay. For any prescription drugs included on Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.

Retail (Up to a 31-day supply)	**BCBSKS Buy-Up**	**BCBSKS Core**	**BCBSKS HDHP**
			Subject to Medical Deductible then:
Tier 1 Generic	$15.00	$15.00	$15.00
Tier 2 Preferred	$50.00	$50.00	$50.00
Tier 3 Non-Preferred	$75.00	$75.00	$75.00
Tier 4 Specialty	$150 for Preferred and 20% up to $250 for Non-preferred	$150 for Preferred and 20% up to $250 for Non-preferred	$150 for Preferred and 20% up to $250 for Non-preferred
Mail Order (Up to a 90-day supply)	**BCBSKS Core**	**BCBSKS Buy-Up**	**BCBSKS HDHP**
			Subject to Medical Deductible then:
Tier 1 Generic	$37.50	$37.50	$37.50
Tier 2 Preferred	$125.00	$125.00	$125.00
Tier 3 Non-Preferred	$187.50	$187.50	$187.50
Tier 4 Specialty	See **Express Scripts®** information below		

Mail Service Pharmacy:

Blue Cross Blue Shield of Kansas offers home delivery through **Express Scripts®** Pharmacy. This 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
- 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

If you're already using home delivery for your medicines.

1. Go to esrx.com/BCBSKS.
2. Register and create a profile.
3. See your active drugs and/or send your refill order.

You can, also download the **Express Scripts®** Pharmacy mobile app from the Apple App Store or Google Play.

If you haven't used home delivery yet, call **833.599.0511** to get started.

PRESCRIPTION DRUG PROGRAM

UPDATES EFFECTIVE 7/1/22

FORMULARY

The list of preferred medication is subject to change periodically. With your Blue Cross Blue Shield medical plan you utilize the ResultsRX formulary list. Members can obtain the most accurate prescription drug coverage information at the Blue Cross Blue Shield Prescription (formulary) drugs webpage at www.bcbsks.com/drugs.

NEW! MANDADATORY GENERIC PROGRAM:

Generic Mandatory – Effective 7/1/22 Generic medications will be mandatory unless the prescription practitioner has provided the override to receive the brand name drug. If the member does not have the doctor override, the member is responsible for any cost difference above the copay. For any prescription drugs included on Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.

PRESCRIPTION DRUG SUPPLY REFILL/ REISSUE

Prescription refill available after 75% depletion on mail order for controlled and non-controlled substances. Prescription refill available after 75% depletion for non-controlled substances or 85% depletion for controlled substances at retail pharmacy. Change from 2/3 of previously issued supply was exhausted.

DIABETIC SUPPLIES

Continuous Glucose Monitors have been added to the list of diabetic supplies.

SELF-ADMINISTERED IV DRUGS

Coverage for certain self-administered Iv drugs including hemophilia drugs will be covered under the pharmacy benefit (they would currently be covered under the medical plan).

Changes to the Pharmacy benefits are effective on 7/1/22! Let you providers know when you next fill your prescriptions!

GOODRX

GoodRx compares prices for your prescriptions at pharmacies near you. GoodRx does not sell medications, they tell you where you can get the best deal on them. By using Good Rx, the charges might not go towards your deductible.

GoodRx will show you prices, coupons, discounts, and savings tips for your prescriptions.

You can access GoodRx by going to **www.goodrx.com**, or by downloading the app.

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

A savings account where you can direct pre-tax payroll deductions to be used to pay for qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep—the HSA is owned by you, just like a personal checking or savings account.

Contribute up to **$3,650*** Single, or **$7,300*** Family

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds—or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the District, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future —even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses—even if they're not covered by your medical plan.

2022 MAXIMUM CONTRIBUTIONS

Single coverage	**$3,650**
Family coverage	**$7,300**
Catch up for age 55 or older	**$1,000**

You can put money into your HSA on a pre-tax basis with regular payroll deductions. The District utilizes UMB as the HSA administrator for payroll deductions.

WHAT ARE THE RULES?

- **You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.**
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or Tricare due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also QHDHP.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications).
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.
- Make sure to name, update, and add your beneficiary information.
- If you are age 55 or older, you can make an extra $1,000 "catch-up" contribution each year.
- There is a monthly administrative fee of $2.45 you must pay UMB for your HSA account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

This may be the best plan option for you if any of the following is true:

- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre -tax income to a Health Savings Account.

Monthly Administration Fee: $2.45

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Blue Cross Blue Shield of Kansas. You usually will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from Blue Cross Blue Shield of Kansas that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to www.bcbsks.com.

FLEXIBLE SPENDING ACCOUNTS

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses for you and your dependents that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year.

BE AWARE: Any unused portion of the account over $570 is forfeited.

Eligible Expenses Examples

- Alcoholism treatment
- Artificial limbs
- Ambulance
- Braces
- Chiropractors
- Coinsurance and copayments
- Contact lens solution
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Dermatologists
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible Amounts
- Laboratory fees
- Licensed osteopaths
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Obstetrical expenses
- Oxygen
- Prescription drugs
- Podiatrists
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Smoking cessation programs
- Sterilization and reversals
- Substance abuse treatment
- Surgical expenses
- Prescribed vitamin supplements (medically

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit your receipt with a claim form to ASI to be reimbursed.

2. SELECT YOUR FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**
- ☐ **You MUST re-enroll into these accounts affirmatively every plan year**

2022 Maximum Contributions

Account	Maximum
Health Care Flexible Spending Account	$2,850 max
Dependent Care Expense Account	$5,000 max

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes).

Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800.659.3035, or log on to www.asiflex.com to review your FSA balance.

At www.asiflex.com you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

Monthly Administration Fee $3.00

CARE OPTIONS AND WHEN TO USE THEM

It is a good idea to visit the care provider's website to be sure that the facility is in-network. You can check this by calling the toll-free number on the back of your medical ID card, or by visiting bcbsks.com.

KNOW WHERE TO GO.

Your primary care provider usually has easy access to your records, knows the bigger picture of your health, and many offer same-day appointments to meet your needs. When seeing your provider is not possible, however, it's important to know your quick care options to find the place that's right for you and help avoid financial surprises.

Quick Care Options	Needs or Symptoms
Virtual Visits Anywhere, anytime online doctor visits. To learn more, log in to bcbsks.com/telemedicine.	• Cold • Flu • Fever • Pinkeye • Sinus
Convenience Care Clinic Treatment that's nearby.	• Skin Rash • Flu shot • Minor Injuries • Earache
Urgent Care Center Quick after-hours care.	• Low back pain • Respiratory illness (cough, pneumonia, asthma) • Stomach illness (pain, vomiting, diarrhea) • Infections (skin, ear/nose/throat, genital-urinary) • Minor Injuries (burns, stitches, sprains, small fractures)
Emergency Room (ER) Care for serious needs.	• Chest pain • Shortness of breath • Severe asthma attack • Major burns • Severe injuries • Kidney stones

Ask before you enter:

1. Is this an Urgent Care Center or ER?
2. Is this facility a network provider?

Freestanding ERs

Many people have been surprised by their bill after visiting a freestanding emergency room (FSER). FSERs, sometimes referred to as urgency centers, can be 2x the cost of an ER and 20x the cost of an Urgent Care Center. Neither located in nor attached to a hospital, FSERs are able to treat similar conditions as an ER but do not have an ER's ability to admit patients.

PRIMARY CARE

For routine, primary/preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

CONVENIENCE CARE

These providers are a good alternative when you are not be able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as Walgreens), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours - or if you can't be seen by your doctor immediately - you may consider going to an Urgent Care Center, where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in serious injury or is life-threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

VIRTUAL VISITS

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes, and the doctor can write a prescription, if needed, that you can pick up at your local pharmacy. See Page 15 for more detail.

MEDICAL RESOURCES

DISEASE AND WELLNESS MANAGEMENT

HealthyOptions

PERSONALIZED SUPPORT

At Blue Cross and Blue Shield of Kansas, telephone-based disease and wellness management programs are designed to help you improve your quality of life and overall health. When you enroll in one of the following programs, we will provide **one-on-one support, coaching and education** through regular telephone calls.

- Asthma[1]
- COPD
- Diabetes[1]
- Heart disease
- High cholesterol
- High blood pressure
- Maternity[2]
- Stress management
- Tobacco cessation[2]
- Weight loss

[1] Ages 5+
[2] No age restrictions

NO ADDITIONAL COST

These are provided at no additional cost to your existing health plan and will not affect your benefits. You can participate if you are an enrolled member and have Blue Cross and Blue Shield of Kansas as your primary health insurance carrier.

HEALTH EDUCATION

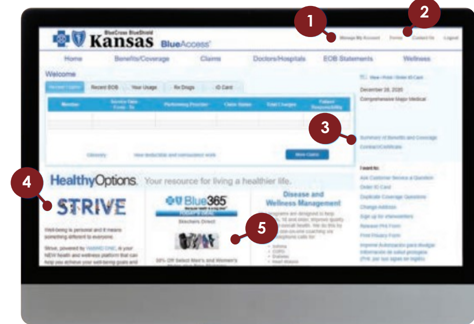
Knowledge is power! During routine calls, registered nurses will gather your health information and send you educational materials that will help you take an active role in your health and healthcare.

Our registered nurses can help you:

- Better understand your health risks and possible complications
- Make healthy lifestyle choices
- Improve communications with your healthcare team (doctors, nurses and others)
- Make informed health decisions

GETTING STARTED WITH BLUEACCESS®

1. **Manage My Account** | Edit and manage your preferences and go paperless.
2. **Forms** | Order a new ID card, find authorization forms and other forms related to your health insurance coverage.
3. **Summary of Benefits and Coverage (SBC) and Contract/Certificate** | View details about your coverage and contract.
   - View your copay, deductible and coinsurance amounts
   - Common medical coverage information
   - Coverage for specific tests or treatments
4. **Strive, powered by WebMD ONE** | Use this health and wellness platform to take a Health Assessment and generate a personalized health plan to reach your well-being goals.
5. **Blue365 ®** | Exclusive health and fitness deals and discounts.



MEDICAL RESOURCES

TELEMEDICINE

See a doctor from the comfort of your own home – or anywhere else for that matter. Safe and secure, it's the quality care you need, made easier.

HEALTH EDUCATION

Telemedicine, also called telehealth, is an alternative to in-person visits. It allows healthcare professionals to evaluate, diagnose and treat patients at a distance via secure video/audio connections.

With Blue Cross and Blue Shield of Kansas coverage, you can visit live with a doctor on your computer or mobile device when it's convenient for you.

If you are in need of telemedicine services, call your doctor first. If your doctor does not provide this service, call toll-free **844-733-3627** to see what other telemedicine options may be available to you.

WHEN CAN I USE IT?

Consult a doctor for common conditions like:

- Cold/Flu
- Fever
- Rash
- Sinus infection
- Pink eye
- Ear infection
- Behavioral health

PATIENT BENEFITS

- Less time away from work
- No travel expenses or time
- Easier if you have a child or elder in your care
- Privacy
- No exposure to other potentially contagious patients

For more information, please visit bcbsks.com/telemedicine.

DOCTOR FINDER INFO

Find doctors, pharmacies and hospitals participating in the Blue Cross and Blue Shield of Kansas network. Go to bcbsks.com/find-a-doctor where you can log in to your member portal or simply search for a Doctor or hospital.

COST TRANSPARENCY TOOL

Get the care you need and save money! With the cost transparency tool, you can compare costs before you go to the doctor. Log into BlueAccess for more details at bcbsks.com/blueaccess.

BLUE365®

Get the health and fitness products you've been wanting with a little help from our member discount program. Sign up at blue365deals.com.

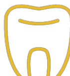
STRIVE

Use this health and wellness platform to take a Health Assessment and generate a personalized health plan to reach your well-being goals. Login to your BlueAccess account to enroll or visit bcbsks.com/strive.

GEOBLUE

Get affordable travel medical insurance with GeoBlue®. From Hospitalizations, emergency evacuations to an elite provider network. Go to bcbsks.com/travel for more information.

VOLUNTARY DENTAL INSURANCE



DELTA DENTAL IS THE DENTAL CARRIER FOR 2022

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

3. REVIEW YOUR DENTAL PLAN

FIND A DENTIST

To find a Delta Dental of Kansas provider in your area, visit the website at www.deltadentalks.com

DIRECTIONS:

- Click "Member" in the tool bar
- Click on "Find a Provider", then "Find a Dentist"
- Select the Delta Dental PPO or the Delta Dental Premier network
- Enter your ZIP Code
- Click "Search for a Dentist" for a comprehensive directory of dentists

In-Network Providers: Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

Dental Insurance Plan Options and Costs

Delta Dental	Employee Cost Per Month
Employee Employee & Spouse Employee & Child(ren) Employee & Family	\$44.02 \$86.90 \$90.07 \$150.27

	PPO Network	Premier Network		
Deductible Individual Family	\$25 \$75		Applied to Type B & C Services	
Maximum Benefits Annual	\$1,500		Applied to Type A, B & C Services	
A. Preventive Services	100%	100%	• Diagnostic X-rays • Full Mouth X-Rays • Panoramic X-Rays • Sealants	• Topical Fluoride (children) • Prophylaxis: cleanings • Space Maintainers
B. Basic Services	80%	80%	• Periodontics • Endodontics	• Fillings & crown repair • Oral surgery—simple extractions
C. Major Services	50%	50%	• Major Restorative Services (crowns) • Implants • Surgical Periodontics	• Dentures • Bridges

VOLUNTARY VISION INSURANCE

SUPERIOR VISION IS THE VISION CARRIER FOR 2022

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery, there is a discount available with some providers. To find a participating provider, go to www.superiorvision.com.

Dependent children are eligible until the end of the month in which they turn age 26.

Vision Insurance Plan Options and Costs

BCBSKS	Employee Cost Per Month	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$10.19 $20.19 $19.75 $30.05	
	In-Network	**Out-of-Network**
Copays Examination Materials	$10 copay $25 copay	Reimbursement $26-34 Refer to schedule below
Frequency of Service Exam Contact Lenses/Fitting Lenses Frames	Every 12 months Every 12 months Every 12 months Every 24 months	
Lenses* Single Bifocal Trifocal	$0 copay $0 copay $0 copay	Reimbursement $29 $43 $53
Frames**	$125 allowance, 20% off balance over $125	Reimbursement $65
Conventional Contacts** *(allowance includes materials only)*	$120 allowance, 20% off balance over $120	Reimbursement $100
Contacts Lens Fitting Standard Specialty	$25 copay $25 copay	N/A

** If only new lenses are bought and don't purchase frames at the same time, the copay would apply to lenses alone.*
*****Discount Features:** Look for providers in the Provider Directory who accept discounts, as some do not; please verify services and discounts prior to service as they vary.*

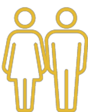
4. REVIEW YOUR VISION PLAN

FIND A PROVIDER

- Visit the website at www.superiorvision.com
- Under the Member Tab you can quickly find a provider by clicking on "Locate a Provider"
- Enter your location information and select the "Insurance Through Your Employer" option
- Pick the Superior National network and choose your desired distance
- Click the "Find Providers" button
- OR, you can call 800.507.3800 to speak with a Customer Service representative

VOLUNTARY LIFE AND DEPENDENT LIFE INSURANCE

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP



VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase Life and AD&D Coverage for yourself and your eligible dependents. Reliance Standard guarantees coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life:** minimum $10,000 to a maximum of $500,000, in $10,000 increments. The guarantee issue is:
    - Under age 60: $100,000
    - Age 60 but under age 70: $10,000
    - Age 70 or older: none
- **Optional Dependent Life for spouse:** minimum $10,000 up to $500,000 maximum, in $10,000 increments. The guarantee issue is:
    - Under age 60: $30,000
    - Age 60 or older: none
- **Optional Dependent Life for children:** the benefit is $10,000. Guarantee issue up to $10,000. (Age 14 days to 6 months the benefit is $1,000).
- If you don't enroll in the Voluntary Life plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Reliance Standard before you're able to get coverage in the future.
- You must be enrolled in the Voluntary Life program in order to have coverage for your spouse and dependent children.

TIP **Benefits reduce due to age. See Certificate for details.**

5. REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

Voluntary Life and AD&D and Dependent Life Options and Costs

	Age	Employee Rates per $10,000 of coverage	Spouse* Rates per $10,000 of coverage
Voluntary Life and AD&D	<30	$1.04	$1.04
	30-34	$1.00	$1.00
	35-39	$1.26	$1.26
	40-44	$1.84	$1.84
	45-49	$2.88	$2.88
	50-54	$4.60	$4.60
	55-59	$7.47	$7.47
	60-64	$8.99	$8.99
	65-69	$13.00	$13.00
	70-75	$24.16	$24.16
	Child(ren)	$1.74/month per $10,000 coverage	

**Spouse rate is based on the employee's age.*

VOLUNTARY SHORT-TERM DISABILITY

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

6. REVIEW YOUR DISABILITY COVERAGE

- SHORT-TERM DISABILITY

SHORT-TERM DISABILITY INSURANCE IS OFFERED THROUGH RELIANCE STANDARD.

WHO IS ELIGIBLE?

Each Active Full-Time Employee working 30 hours or
more per week and earning a minimum salary of $15,000 per year, except any person working on a temporary or seasonal basis.

WHEN DO MY BENEFITS BEGIN AND HOW LONG WILL I RECEIVE BENEFITS?

You may select from the following elimination period and benefit duration options:

- Option 1 – 0 days for injury, 7 days for sickness, 26 week duration
- Option 2 – 7 days for injury, 7 days for sickness, 25 week duration
- Option 3 – 14 days for injury, 14 days for sickness, 24 week duration
- Option 4 – 30 days for injury, 30 days for sickness, 22 week duration

WHAT IS THE BENEFIT AMOUNT?

You may elect a weekly benefit in increments of $25 from a minimum of $100, up to a maximum benefit of $1,500, not to exceed 60% of covered earnings. If at any time the weekly benefit you have chosen exceeds 60% of your covered earnings, your benefit amount will be reduced to the highest increment for which you are eligible.

WHAT FEATURES ARE INCLUDED IN MY PLAN?

- Maternity covered as any other illness
- Non-occupational coverage
- Partial Disability benefit included
- Pre-Existing Condition Limitation – 3/12
- Zero Day Residual included Definition

EXCLUSIONS

Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; sickness covered by workers' compensation or other workers' disability law; injury occurring out of or in the course of work for wage or profit.

For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances.

While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered—from deductibles and copays to living expenses.

This Critical Illness insurance policy from Prosperity can help with the treatment costs of a covered critical illnesses—such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses. You can choose to add Cancer Insurance to your Critical Illness plan.

7. REVIEW YOUR VOLUNTARY COVERAGE

- ☐ **Critical Illness coverage**
- ☐ **Cancer Insurance**
- ☐ **Permanent Life with Long Term Care Insurance**
- ☐ **Accident Insurance**
- ☐ **Hospital Indemnity Insurance**
- ☐ **Identity Protection**
- ☐ **Legal Services**
- ☐ **403 (b)**

GROUP CRITICAL ILLNESS COVERAGE INCLUDES:

- **$50 Health Screening** Benefit
- Reoccurrence Benefit for multiple situations – pays 100% of initial benefit (Events must be separated by 180 days.)
- Employee chooses: **$2,500** to **$50,000** of coverage.

Critical Illness Benefit payable for:

- Heart Attack – 100%
- Stroke – 100%
- Coronary Artery Bypass Graft – 50%
- Major Organ Transplant- 100%
- Kidney Failure – 100%
- Paralysis – 100%
- Coma – 100%
- Severe Burns – 100%
- Motor Neuron Disease/ ALS – 100%
- Advanced Alzheimer's Disease - 100%
- Cancer - 100%
- Cancer InSitu– 50%

FEATURES:

- Benefits are paid directly to you, unless you choose otherwise
- Coverage is available for you, your spouse, and dependent children
- You can take your coverage with you if you change jobs or retire (with certain stipulations)

HOW CRITICAL ILLNESS COVERAGE WORKS

1. Critical Illness coverage is selected
2. You experience chest pains and numbness in your left arm
3. You visit the emergency room
4. A physician determines that you have suffered a heart attack
5. Aflac Critical Illness coverage pays you a First Occurrence Benefit

VOLUNTARY CANCER COVERAGE

Focus less on finances and more on treatment and recovery!

No one wants to experience a cancer diagnosis, but the fact is that the risk of getting cancer is great. In the United States, men have slightly less than a one in two lifetime risk of developing cancer; for women, the risk is a little more than one in three (Cancer Facts and Figures 2012, American Cancer Society). Prosperity Cancer plans can assist you with a variety of expenses so you can focus on getting better. You can spend the benefits however you want, on direct or indirect costs associated with the illness.

Why do I need cancer coverage?

Cancer plans can assist you with a variety of expenses so you can focus on getting better. You can spend the benefits however you want, on direct or indirect costs associated with the illness:

• Make your mortgage payments
• Hire extra help for around the house, such as in-home caregivers
• Help cover medical bills as well as therapy and training
• Pay for travel to treatment facilities away from home - and for family Visits

In addition to the physical and emotional effects, people who are diagnosed with cancer may see a costly impact on their expenses. You may need additional help to absorb the expense of paying for drugs and other direct and indirect costs associated with cancer.

Here is how it works:

Benefit payments are made directly to you in most cases, placing you in control at a time when you may feel that your options are limited. The first occurrence diagnosis benefit is available to you after your initial diagnosis of internal cancer, so it is there when you need it most. You'll save on your premiums because coverage through your employer typically is less expensive than purchasing on your own. You can pay premiums through automatic payroll deduction, and you can continue the coverage even if you change employers.

Cancer Monthly Costs	Level 3	Level 2	Level 1
Employee Only	$32.15	$23.40	$16.34
Employee & Spouse	$50.10	$36.67	$25.78
Single Parent	$36.07	$26.41	$18.54
Family	$54.06	$39.71	$28.02

PERMANENT LIFE INSURANCE WITH LONG-TERM CARE

LIFE INSURANCE WITH LONG-TERM CARE

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. Universal Life Events can help.

The Universal Life Events option offers a higher death benefit during your working years, when your needs and responsibilities are the greatest.

Universal Life Events includes a long-term care (LTC) benefit that can help pay for these services at any age. This benefit remains at the same level throughout your life, so the full amount is always available when you most need it.

COVERAGE AMOUNTS:

Employee Only coverage - guarantee issue amount up to $100,000

Spouse coverage - guarantee issue amount greater of the amount purchased by $3.00 per week to $15,000

Child coverage- guarantee issue amount purchased by $3.27 through $4.56 per week

Grandchildren coverage - Legal Dependent amount purchased by $3.27 through $4.56 per week with medical questions

Guarantee Issue amounts listed above are for the Initial Eligibility Period Only.

PROTECT YOUR FUTURE

FEATURES:

- You can collect 4% of your Universal Life Events death benefit per month for up to 25 months to help pay for long-term care services.
- Accelerated death benefit—75% of death benefits when diagnosed with a terminal illness.
- If you collect a benefit for long-term care, your full death benefit is still available for your beneficiaries.
- Apply for coverage for family members—spouse, children and grandchildren
- Keep your coverage at the same price and benefits if you change jobs or retire.
- Waive your policy payments if your doctor says you are totally disabled.
- Rates are based on employee and spouse age and smoker status. Note: your rate is "locked in" at your age at purchase.

ACCIDENT INSURANCE

Guardian

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room—and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in.
In the event of an off job covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of.

GUARDIAN ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches, and casts

BENEFITS INCLUDE:

- A Wellness Benefit for covered preventive screenings
- Transportation and Lodging Benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

FEATURES:

- Coverage is guarantee-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- Fast claims payment. Most claims are processed in about four business days

Guardian	Option 1: Value Plan	Option 2: Premier Plan
	Monthly Cost	
Employee	$12.25	$14.70
Employee + Spouse	$24.50	$29.40
One Parent Family	$28.55	$34.40
Two Parent Family	$40.80	$49.10

HOW ACCIDENT INSURANCE WORKS

1 You select Accident Insurance

2 You injure your leg in a covered accident and go to the hospital by ambulance

3 The ER doctor diagnoses a fracture and treats you

4 You hobble out of the hospital on crutches

5 The Guardian pays your benefit

HOSPITAL INDEMNITY

Voluntary Hospital Indemnity insurance through Reliance Standard provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment.

HOW IT WORKS:

You'll be reimbursed specified amount for covered hospital confinement, exams, and office visits. Benefits are paid directly to you and you can use the cash however you want.

BENEFITS

Hospital Room & Board Benefits	
Room & Board Benefit per Day (180 Daily Benefits per Coverage Year)*	$100
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$500
Hospital Critical Care Admission Benefit	
One Daily Benefit per Coverage Year	$500
Non-Insurance Services	
On-Call Travel Assistance	Included

**In no event will the Daily Benefits exceed 180 daily benefits per Coverage Year.*

Hospital Indemnity	
Employee	$14.27
Employee + Spouse	$25.64
Employee + Children	$19.94
Employee + Family	$30.91

FEATURES:

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions
- Mental & Nervous and Substance Abuse treated same as any other hospital admission
- No deductibles
- Eligible for continuation of coverage
- HIPAA privacy compliant
- Overlying Major Medical Plan NOT Required
- Coverage Offered on a Voluntary Basis

IDENTITY PROTECTION

IDENTITIY FORCE IDENTITY THEFT

Every three seconds, someone becomes a victim of identity theft. If you haven't had your identity stolen, you probably know someone who has. Identity theft occurs when someone steals your personal information and uses it without your knowledge to commit fraud or other crimes. It's a growing problem, affecting 11.1 million adults in the United States just last year, according to a survey by Javelin Strategy & Research.

Identity theft is the fastest growing crime in the U.S. It has been listed as the #1 consumer complaint for 12 consecutive years. The crime can be devastating, and is often costly and time-consuming to resolve. According to the Federal Trade Commission:

- Consumers suffered total fraud losses of $18 billion in 2013.
- Consumer out-of-pocket costs averaged $400 per victim, with the average victim suffering a loss of $2,294.
- Total time spent to resolve cases averaged more than 11 hours per victim.

Help prevent being a victim of Identity Theft and learn how Identity Force cannot only help prevent but also restore your identity should you join the growing number of victims across the country!

Plans and pricing

$9.50 per person / month

$17.50 per family / month

IDENTITY MONITORING

- Financial Account Takeover Monitoring (Available Q2 2021)
- Mobile Attack Control
- Secure My Network (VPN)
- Online PC Protection Tools
- Password Manager
- Bank and Credit Card Activity Alerts
- Identity Vault and Secure Storage
- Auto On Monitoring Advanced Fraud Monitoring (Instant Inquiry Alerts)
- Change of Address Monitoring
- Court Records Monitoring
- Fraud Alert Reminders
- Dark Web Monitoring

CREDIT MONITORING

- Identity and credit monitoring
- Credit Report Assistance
- Credit Freeze and Lock Assistance
- Credit Score Simulator and Tracker

RESTORATION SERVICES

- Ransomware Expense Reimbursement ($25,000)
- Social Engineering Expense Reimbursement ($25,000)
- Senior Fraud Resolution
- Deceased Family Member Fraud Remediation*
- Identity Theft Insurance $2,000,000
- Stolen Funds Reimbursement
- Any Financial Account Covered

LEGAL SERVICES

MetLife provides you with telephone and office consultations for an unlimited number of matters with the attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action.

PLAN FEATURES

- Estate Planning Documents
- Financial Matters
- Real Estate Matters
- Elder Law Matters
- Family Law
- Traffic Offenses
- Document Preparation
- Immigration Assistance
- Juvenile Court Defense
- Consumer Protection
- Defense of Civil Lawsuits
- Personal Property Protection

Monthly Rate	MetLife Legal Plan
Employee Only or Family	$18.75

FOR MORE INFORMATION:
Visit **info.legalplans.com** and enter access code: **LEGAL** or call our Client Service Center at **1-800-821-6400** Monday - Friday from 8am to 8pm (Eastern Time).

ADDITIONAL FEATURES

- **E-Services**
  - Attorney Locator
  - Life Guide
  - Free, downloadable legal documents
  - Links to resources for financial planning, insurance and work/life matters
- **Family Matters**
  - Separate plan for parents of participants for estate planning documents
  - Available for an additional fee
- **Reduced Fees**
  - Network attorneys provide representation for personal injury, probate and estate administration matters at reduced fees

Group legal plans and Family Matters provided by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, group legal plans and Family Matters provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Please contact Hyatt Legal Plans for complete details on covered services including trials. No service, including advice and consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife® and affiliates, and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters listed above under Legal Representation. *Not available in all states. **For Family Matters, different terms and exclusions apply.

403(B) RETIREMENT PLAN

OUR 403(B) PLAN

The Tax-Sheltered Annuity (TSA) Program is a supplemental retirement savings program authorized by section 403(b) of the Internal Revenue Code.

Through the TSA Program you can invest a portion of your income for retirement on a pre-tax basis. Participation in the USD 409 TSA Plan is voluntary. You make the entire contribution; there is no employer match.

Investment options include a wide array of mutual funds and fixed and variable annuities managed by six authorized investment companies.

To enroll, change your contribution and receive more information on this plan, contact one of the following approved investment providers:

- Start **NOW**. Don't wait. Time is critical.
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investments.
- Use automatic deductions from your payroll or your checking account for deposit into mutual funds, your IRA or other investment vehicles.
- Save regularly. Make saving for retirement a habit.
- Be realistic about investment returns. Never assume that a year or two of high market returns (or market declines) will continue indefinitely.
- Roll over retirement account money if you change jobs.
- Don't dip into retirement savings.

Investment Provider	Contact Name	Contact Phone
AXA Equitable Life Insurance	Mark L. Begly, CLU Guy "Criss" Brown	913-367-0826 913-345-2800
MetLife Midwest Associates	Julie Avey	913-367-2354
Security Benefit	Terry Clark (OFG Financial Services) Brad R. Flipse (OFG Financial Services)	913-962-9911 913-962-9911
Security Distributors, Inc.	Terry Clark (OFG Financial Services) Brad R. Flipse (OFG Financial Services)	913-962-9911 913-962-9911

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Atchison Public Schools 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 Atchison Public Schools 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. Atchison Public Schools has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Kansas health 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 Atchison Public Schools coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Atchison Public Schools medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

This notice is a summary. For a full description of all of Atchison School District's Benefit plans, please contact the Customer Service at 800-432-3990 or csc@bcbsks.com.

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 Atchison Public Schools 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 or call the Payroll Department at 816-268-7066 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 Atchison Public Schools 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:	July 1, 2022
Name of Entity/Sender:	HR Department
Contact--Position/Office:	Lori Lanter
Address:	626 Commercial Street Atchison, KS 66002
Phone Number:	913.367.1161

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.
- Treatment of physical complications at all stages 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 this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call Human Resources.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

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NOTICE REGARDING WELLNESS PROGRAM

Atchison Public Schools wellness program is a voluntary program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Additional incentives may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Atchison Public Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

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Premium Assistance Under Medicaid and theChildren'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 premiumassistance 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 yourState 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 dependentsmight 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 eligiblefor premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-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://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
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-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: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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To see if any other states have added a premium assistance program since January 31, 2022, or for more information on

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, anddisplays 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 personshall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 1/31/2023)

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Atchison Public Schools's HR department.

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

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MARKETPLACE COVERAGE OPTIONS CONTINUED

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.

Employer Name: Atchison Public Schools	Employer Identification Number (EIN): 48-0697623
Employer Address: 626 Commercial Street Atchison KS 66002	Employer Phone Number: 913-367-1161
Who can we contact about employee health coverage at this job? Lori Lanter	Phone Number: 913-367-1161 Email Address: llanter@usd409.net

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:
  - X Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the first day of the month, following date of hire.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - X We do offer coverage. Eligible dependents are: Spouses, Domestic Partners, and children that meet eligibility requirements.
  - ☐ We do not offer coverage.

X 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, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the Deductible has been met. You pay any remaining percentage of the cost until the Out-of-Pocket Maximum is met. Coinsurance percentages will be different between in-network and non -network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the Deductible, but will go toward the Out-of-Pocket Maximum. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the Deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The Deductible, Coinsurance and Copays are included in the Out-of-Pocket Maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific Copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90 -day supply. Sometimes the Deductible must be satisfied before Copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a Deductible, Coinsurance or Copayments.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

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The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.