

EMPLOYEE BENEFITS GUIDE 2019



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Eligibility & Enrolling

USD 437 is proud to offer you and your eligible family members a comprehensive benefits package. Making well-informed decisions about your benefits is an important part of being a consumer within a challenging health care system. It's also increasingly important to select the right benefits to meet you and your family's needs in order to effectively manage health care services and their costs.

Who Is Eligible?

- 12 month employees hired to work four or more hours per day
- 9 month employees hired to work 28.75 or more hours per week
- Your lawful spouse
- Dependent child(ren) up to age 26

When Does Coverage Become Effective?

- New hires—first of the month following a 31 day waiting period
- Existing employees—the new benefit period begins January 1, 2019—December 31, 2019

How to Enroll?

New Hires

New Hires will meet with a representative from American Fidelity to make initial benefit elections.

Open Enrollment Elections

All benefit eligible employees can access the American Fidelity self-enrollment portal from October 29th—November 9th at <https://benefits.americanfidelity.com/usd-437-auburn-washburn>.

Once you have made your elections you will **not** be able to change them until the next open enrollment period unless you experience a qualified life event.

“If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 21-22 for more details.”



Qualifying Events

You have the option under the USD 437 flexible benefits plan to elect medical, dental and vision coverage as well as the health care and dependent care flexible spending accounts. Your share of the premiums for these benefits will be deducted from your pay pre-tax. If you fail to elect coverage within the annual open enrollment or new hire eligibility period, you will be deemed to have voluntarily waived eligibility for the respective coverage for the entire year. Once made, pre-tax benefit elections are irrevocable and remain in effect for the plan year unless you have a “Qualified Life Event”. Other elective benefits will be paid after tax.

When Can I Make Changes?

Life is full of changes; expected and unexpected. Generally, you may change your benefit elections only during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including—but not limited to:

- Marriage
- Divorce
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child that causes a change in eligibility for other coverage
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

PLEASE NOTE:

You must notify the Business office within 30 days of the qualified life event. If you do not contact the Business Office within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event). Depending on the type of event, you may be asked to provide proof of the event. **Enrollment forms are due back to the Business office within 30 days of the qualified life event.**

Qualified Life Event	Documentation to Submit
Dependent loss of the state's CHIP plan	>> A copy of the Certificate of Creditable Coverage or a termination letter which lists the date coverage ended
Judgement, decree or court order to add coverage for a dependent child	>> A copy of the court order awarding custody or requiring coverage
Legal marriage	>> Proof of marriage such as marriage certificate or jointly filed tax return
Birth or adoption	>> Proof of birth or adoption
Death of your spouse or dependent	>> A copy of the death certificate
Change in employment status	>> A copy of the Certificate of Creditable Coverage or a termination letter which lists the date coverage ended



12 Month Employee Premiums

USD 437 contributes **\$450.07** to the medical plan premiums and offers wellness premium incentive(s) to employees enrolled in the medical plan as a continued effort to encourage healthy habits. You have the opportunity to reduce your monthly medical premiums by **\$40**.

- Receive **\$20** if you are a Non-Tobacco User (must complete a Non-Tobacco Affidavit during Open Enrollment) or participate in an approved Tobacco Cessation program
- Receive **\$20** if you complete a Biometric Screening at an onsite event or via your own healthcare provider

Medical			
	Non-Tobacco & Biometric Screening	Non-Tobacco Only OR Biometric Screening Only	No Wellness Participation
Option 1 PPO \$1,500			
Single	\$136.73	\$156.73	\$176.73
Employee + Spouse	\$808.60	\$828.60	\$848.60
Employee + Child(ren)	\$719.43	\$739.43	\$759.43
Family	\$1,391.31	\$1,411.31	\$1,431.31
Option 2 HDHP \$3,500			
Single	\$0.00	\$20.00	\$40.00
Employee + Spouse	\$515.22	\$535.22	\$555.22
Employee + Child(ren)	\$447.15	\$467.15	\$487.15
Family	\$962.37	\$982.37	\$1,002.37
Dental			
Comprehensive Plan	Monthly Premium		
Single	\$32.58		
Employee + Spouse	\$64.00		
Employee + Child(ren)	\$61.56		
Family	\$104.45		
Vision			
Comprehensive Plan	Monthly Premium		
Single	\$9.35		
Employee + Spouse	\$14.96		
Employee + Child(ren)	\$17.26		
Family	\$29.36		
Materials Only Plan	Monthly Premium		
Single	\$11.58		
Employee + Spouse	\$18.54		
Employee + Child(ren)	\$21.38		
Family	\$36.38		



9 Month Employee Premiums

9-Month employees are eligible to receive the wellness premium incentives as outlined on page 4. As an eligible employee, you have the opportunity to reduce your monthly medical premiums by **\$53.34** (**\$26.67** per wellness activity). If benefits become effective after January 1st, then your wellness premium incentive(s) will be pro-rated based on your coverage effective date.

Medical			
	Non-Tobacco & Biometric Screening	Non-Tobacco Only OR Biometric Screening Only	No Wellness Participation
Option 1 PPO			
Single	\$182.31	\$208.98	\$235.65
Employee + Spouse	\$1,078.13	\$1,104.80	\$1,131.47
Employee + Child(ren)	\$959.24	\$985.91	\$1,012.58
Family	\$1,855.08	\$1,881.75	\$1,908.42
Option 2 HDHP			
Single	\$0.00	\$26.67	\$53.34
Employee + Spouse	\$686.96	\$713.63	\$740.30
Employee + Child(ren)	\$596.20	\$622.87	\$649.54
Family	\$1,283.16	\$1,309.83	\$1,336.50
Dental			
Comprehensive Plan	Monthly Premium		
Single	\$43.44		
Employee + Spouse	\$85.34		
Employee + Child(ren)	\$82.08		
Family	\$139.26		
Vision			
Comprehensive Plan	Monthly Premium		
Single	\$12.47		
Employee + Spouse	\$19.95		
Employee + Child(ren)	\$23.01		
Family	\$39.15		
Materials Only Plan	Monthly Premium		
Single	\$15.44		
Employee + Spouse	\$24.72		
Employee + Child(ren)	\$28.51		
Family	\$48.51		



Medical & Rx

Member Pays		
Covered Services	Option 1 PPO	Option 2 HDHP
Annual Deductible		
Individual	\$1,500	\$3,500
Two-or-more persons	\$3,000	\$7,000
Coinsurance <i>(member portion for most services)</i>	40% after deductible has been met	
Maximum Out-of-Pocket		
Individual	\$4,000	\$4,500
Family	\$8,000	\$9,000
Doctor's Office Visits		
Home & Office	\$40 copay	subject to deductible/coinsurance
Telehealth	\$40 copay	\$49
Urgent Care	\$50 copay	subject to deductible/coinsurance
Preventive Care	Paid at 100%	Paid at 100%
Drug Coverage		
Generic	\$15 copay	Subject to deductible; then 50% coinsurance for Generic, Brand, & Mail Order
Brand	\$100/\$200 deductible; then 50% coinsurance	
Mail Order	Generic: \$37.50 copay Brand: subject to brand retail deductible/coinsurance	
Medical Services		
Emergency Medical Transportation		subject to deductible/coinsurance
Inpatient Surgery Physician/Surgical		subject to deductible/coinsurance
Inpatient Facility Fee		subject to deductible/coinsurance
Outpatient Surgery Physician/Surgical		subject to deductible/coinsurance
Outpatient Lab and Radiology		subject to deductible/coinsurance
Advanced Imaging		subject to deductible/coinsurance
Accidental Injury Services		subject to deductible/coinsurance
Emergency Room	\$250 copay; then subject to deductible/coinsurance	subject to deductible/coinsurance
Recovery/Special Needs		
Outpatient Rehabilitation		subject to deductible/coinsurance
Hospice		subject to deductible/coinsurance
Home Health Care		subject to deductible/coinsurance
Mental/Behavioral Health		
Inpatient*		subject to deductible/coinsurance
Outpatient	\$40 office visit copay	subject to deductible/coinsurance
*Requires pre-admission certification from New Directions Behavioral Health at 800-952-5906		



Medical & Rx

The medical benefits are offered through Blue Cross Blue Shield of Kansas. You have the option to seek care in or out-of-network. Blue Choice is the name of the provider network. Using network providers save you and the plan money! An online directory can be viewed at www.bcbsks.com; you will need to choose the **Blue Choice Preferred-Care Blue Network**.

Telehealth

Blue Cross provides telehealth services through American Well® (Amwell). With Amwell, registration is **FREE**, and the cost per visit is less than an emergency room or urgent care visit. It's easy to use, affordable, private and secure. As an innovative patient consultation service, telehealth lets you interact with a doctor at your convenience for common conditions such as cold, flu, fever, sinus infection, rash, etc.

How to Use Amwell

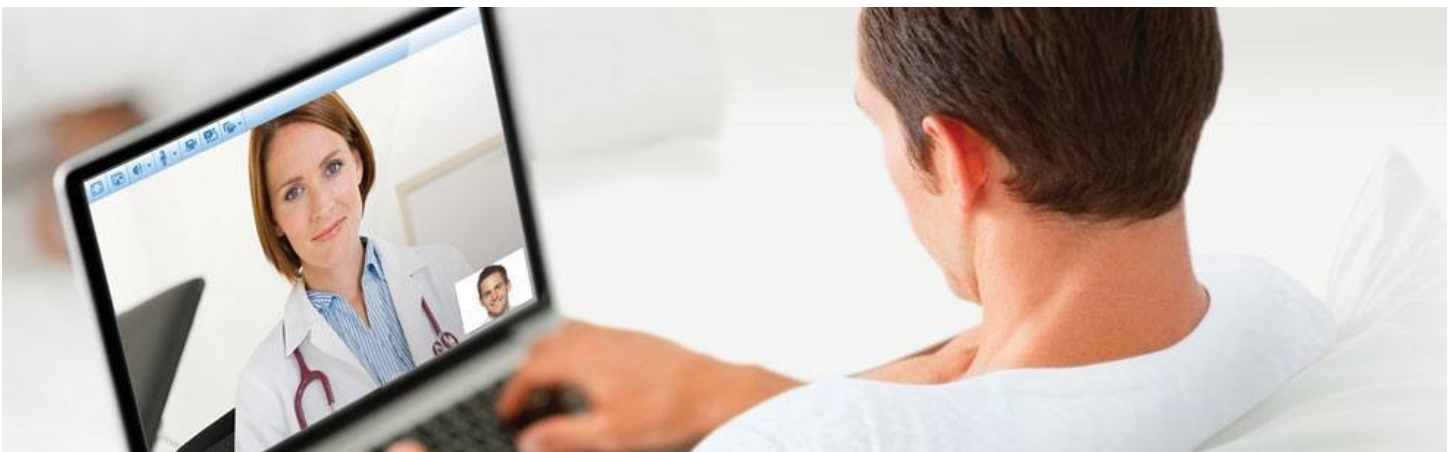
1. Download the Amwell app on any mobile device.
2. On a computer? Visit amwell.com to get started

Why Use Amwell

- Choose your own physician: select from a list of U.S. board-certified doctor and therapist profiles Available nationwide, 24/7/365
- Convenient prescriptions: all prescriptions can be picked up at your local pharmacy
- Easy payment: pay for the visit with credit, debit or HSA/FSA cards.
- Record storage: a complete record of each visit is securely maintained and can be easily accessed

How Much Does Amwell Cost

The cost of an Amwell doctor visit is \$40 for employees enrolled in Option 1, and \$49 for employees enrolled in the High Deductible Health Plan (HDHP). Other covered services include consultation visits with a dietician, social worker, behavioral health professional and psychiatrist at their respective costs.



Prescription Drug Information

Maintenance drugs may be dispensed in supplies up to a maximum of 100 unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy.

BCBSKS is proud to introduce you to the Prime Specialty Pharmacy Program. This program benefits members with conditions requiring specialty medications. Your prescription drug benefit may require you to use Prime Specialty Pharmacy to be eligible for benefits. If you have questions about your specialty pharmacy benefit, please call the phone number on your id card or visit the website below for more information.

To view the drug lists, visit <https://www.bcbsks.com/CustomerService/PrescriptionDrugs>.



Dental



Covered Services	In-Network Benefit
Annual Deductible (Individual/Family)	\$25/\$75
Annual Maximum (per covered person)	\$1,500
Diagnostic & Preventive Care	
Oral evaluations - twice per benefit period	
Bitewing x-rays - twice per benefit period for dependents under age 18; once each 12 months for adults age 18 and over	
Full mouth or panoramic x-rays - once each 5 years	Covered at 100%
Cleanings - twice per benefit period	
Topical fluoride - twice per benefit period for dependents under age 19	
Space Maintainers - for dependents under age 14	
Sealants - once per tooth, per lifetime for dependents under age 16	
Basic Services (subject to deductible)	
Ancillary - 1 emergency exam per benefit period for relief of pain	
Oral surgery—extractions, pre/post operative care	Covered at 50%
Fillings	
Periodontics	
Endodontics - root canal treatments and root canal fillings	
Major Services (subject to deductible)	
Crowns	Covered at 50%
Bridges	
Partial and complete dentures	
Eligible dependents covered to	Age 26





Vision

Comprehensive Plan

Benefits	In-Network Cost
Exam	\$15 copay
Frames (<i>in lieu of contact lenses</i>)	\$130 allowance
Lenses (standard) per pair	
Single Vision	\$25 copay
Bifocal	\$25 copay
Trifocal	\$25 copay
Contact Lens Services & Materials	
Fit & Follow Up Exams	\$25 copay
Elective (in lieu of frames and lens options)	\$130 allowance
Necessary	\$0
Service Frequencies	Every 12 months

Materials Only Plan

Benefits	In-Network Cost
Exam	N/A
Frames (<i>in lieu of contact lenses</i>)	\$200 allowance
Lenses (standard) per pair	
Single Vision	\$25 copay
Bifocal	\$25 copay
Trifocal	\$25 copay
Contact Lens Fitting	
Fit & Follow Up Exams	\$25 copay
Elective (in lieu of frames and lens options)	\$200 allowance
Necessary	\$0 copay
Service Frequencies	Every 12 months





Flexible Spending Account

What is a Flexible Spending Account?

A Flexible Spending Account (FSA), also known as a reimbursement account, allows you to pay for a variety of out-of-pocket health care and dependent care expenses pre-tax. Putting money into a FSA before you pay taxes on it saves you money by lowering your taxable income. The result? **You pay less in taxes each year.** There are three types of FSAs available to you at USD 437:

[Health Care Flexible Spending Account]

Set aside pre-tax dollars from your paycheck to cover eligible health care expenses such as eyeglasses, contacts, copays, deductibles, prescription medications, and orthodontia. The entire amount you set aside is available to use on the first day of your plan year.

[Dependent Care Flexible Spending Account]

Set aside pre-tax dollars from your paycheck to cover eligible dependent care expenses such as day care, babysitting and general purpose day camps for your dependents under the age of 13 while you are at work. You can also use the funds to pay for adult day care services for dependent adults who are unable to care for themselves. You will be reimbursed for eligible expenses as they are incurred and as funds are deposited into your account.

[Limited Flexible Spending Account]

If you're enrolled in a qualified high-deductible health plan (HDHP) and have an HSA, the IRS limits the expenses for which you may be reimbursed under a health care FSA. You may **ONLY** participate in a Limited FSA for **dental** and **vision** expenses. This account lets you take advantage of the savings power of an HSA and a Healthcare FSA simultaneously. Any funds remaining at the end of the plan year will be forfeited.

Other Points to Remember...

- You **must** re-enroll in the Flexible Spending Account(s) each year in order to participate
- Up to **\$500** in unused funds remaining at the end of the plan year will be carried-over to the next plan year for your **Health Care Flexible Spending Account**
- Each of these accounts are separate. You can choose to participate in both, one or neither. The rules and regulations of the IRS govern all FSA accounts.

How Much Can You Contribute?

There are limits on the amount you can contribute to FSAs in 2018:

- Health Care FSA—annual maximum of \$2,650
- Dependent Care FSA—annual maximum of \$5,000 (\$2,500 if married and filing separate)
- Limited Purpose FSA—annual maximum of \$2,650

Plan carefully when deciding how much you want to contribute to your account(s) for the year. You have to use your funds by the end of the benefit period or you forfeit the remaining amount (with the exception of the \$500 carryover provision for a Health Care FSA). The elections you make will remain in effect until the end of the plan year for any reason unless you experience a qualified event or termination of employment.



Health Savings Account

What is a Health Savings Account?

A Health Savings Account (HSA) is a plan designed to help you manage the rising cost of health care by allowing you to set aside money to pay for out-of-pocket medical expenses and to save for retirement. You can think of it as a personal savings account for medical expenses. HSA's are employee-owned, meaning you take the HSA with you if you change employers. Unused funds will earn interest and can be invested until they are withdrawn for eligible expenses or at retirement.

You set aside money on a pre-tax basis—this means as long as you use the money for eligible expenses, you won't pay income taxes on it.

Who is Eligible for an HSA?

- Employees covered by a High Deductible Health Plan (HDHP);
- Employees not covered under another medical plan that is not an HDHP;
- Employees not entitled to Medicare benefits; or
- Employees not eligible to be claimed on another person's tax return.
- Employees who have not received VA benefits in the last 3-months
- Employees not participating in a healthcare FSA account through USD 437 or covered under any other FSA account (i.e. spouse's FSA)

Participating in a HSA is easy.

The Health Savings Accounts are administered through **Silver Lake Bank (21st & Urish Branch)**. To set up your account, visit the Business Office or staff website to complete the HSA Application and necessary enrollment forms. All forms must be returned to the Business office.

Once you've enrolled and set your annual election amount, that amount will be automatically taken out of your paychecks in equal increments throughout the year before you pay federal, state, and FICA taxes on that amount of income. Post-tax contributions can also be made as long as it does not surpass the annual max for that year.

Any unused funds in your HSA will roll over at the end of the year and will continue to earn interest and can be invested until they are withdrawn for medical expenses or until you turn 65 years old, when you can withdraw funds for any reason without incurring penalties.

When do I use my HSA?

After visiting a physician, facility or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles, coinsurance, copays) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense.

Four Tax Advantages of HSA's

100%

100% deductible contributions up to a legally mandated maximum amount



Money withdrawn for medical spending never falls under taxable income



Tax deferred interest earnings



Tax free interest earnings, if money is spent on health care costs



Life Insurance



Term Life Insurance

Term Life Insurance is usually the most affordable type of life insurance. It provides temporary financial protection for your loved ones during your working years. The death benefit pays money directly to your beneficiaries to help with funeral costs and ongoing financial obligations such as daily living expenses, child education and mortgage payments. USD 437 offers two term life insurance plans—American Fidelity Term Life and MetLife Term Life.

Permanent Life Insurance

Permanent life insurance policies do not expire. They are intended to protect your loved ones permanently, as long as you pay your premiums. Some permanent life insurance policies accumulate cash value. That means the value of the policy may grow each year, tax-deferred, until it matches the face value of the policy. The cash can generally be accessed via loans or withdrawals, and can be used for a variety of purposes. This type of policy is typically portable so coverage can continue if employment terminates. USD 437 offers two permanent life insurance plans—American Fidelity Whole Life and Texas Life Permanent Life.

Rates vary based on age, policy type, length of policy, type of policy and dependent type.

Plan Features	AF Term Life	AF Whole Life	Texas Life Permanent Life	MetLife Term Life
Portable	✓	✓	✓	✓
Convertible	✓			✓
Cash Value		✓	✓	
Accelerated Benefit	✓			✓
Coverage for Dependents	✓	✓	✓	✓
Funeral Planning				✓
Will Preparation Services				✓
Estate Resolution Services				✓



Short-Term Disability

If you experience a covered illness or injury, short-term disability can help supplement your income while you are unable to work. USD 437 offers three short-term disability plans to choose from so that you can best meet the needs of your family.

Plan Features

	Plan 1	Plan 2	Plan 3
Benefits Begin	1st day injury 8th day sickness	15th day injury 15th day sickness	31st day injury 31st day sickness
Benefit Amount	Not to exceed 70% of monthly salary	Not to exceed 70% of monthly salary	Not to exceed 70% of monthly salary
Benefit Payable	Up to 180 days	Up to 180 days	Up to 150 days
Hospital Confinement	\$100 per injury \$50 per sickness	\$100 per injury \$50 per sickness	\$300 per injury \$50 per sickness
Accidental Death Benefit	10x monthly benefit	10x monthly benefit	\$50,000

Pre-existing Condition Limitation

No disability benefit will be payable if disability is caused by or resulting from a pre-existing condition and begins before you have been continuously covered under the policy for 12 months. This provision will not apply if you have met the criteria below for 12 consecutive months for such condition(s).

- ⇒ Gone treatment free
- ⇒ Incurred no expenses
- ⇒ Taken no medication
- ⇒ Received no diagnosis or advice from a physician

This limitation will not apply to a disability resulting from a pre-existing condition that begins after you have been continuously covered under the policy for 12 months. Any increase in benefits will be subject to this pre-existing condition limitation. A new pre-existing condition period must be satisfied with respect to any increase applied for and approved by American Fidelity.

There are three optional riders to choose from with the election of short-term disability.

Critical Illness Rider

Receive a one-time lump sum benefit amount ranging from \$10,000—\$25,000 based on diagnosis of the following conditions:

- Heart Attack
- Stroke
- Kidney Failure
- Paralysis
- Major Organ Transplant

Accident Only Spousal Rider

Receive a monthly indemnity amount ranging from \$500—\$2,000 for your spouse who is disabled as a result of a non-occupational accident. Benefits will begin on the 31st consecutive day after the injury and will continue for up to two years.

Hospital Indemnity Rider

Receive a daily benefit amount ranging from \$100—\$150 for an inpatient hospital confinement up to a maximum of 90 days.



Accident

Wellness Benefit	Basic	Enhanced	Enhanced Plus
Annual Routine Physical Exam	\$50	\$75	\$75
Accident Benefit			
Emergency Treatment	\$150	\$200	\$250
Non-emergency Treatment	\$75	\$100	\$125
Medical Imaging (MRI, CT, CAT, PET, US)	\$200	\$200	\$200
Hospital Admission	\$500	\$1,000	\$1,500
Intensive Care Unit	\$300	\$600	\$900
Ambulance (Ground / Air)	\$300/\$1,500	\$300/\$1,500	\$300/\$1,500
Transportation (patient only)	\$300	\$300	\$300
Injury Benefit			
Fracture		\$25—\$3,000	
Laceration		\$25—\$400	
Appliances		\$100	
Torn Knee Cartilage or Ruptured Disc		\$500	
Eye Injury		\$50—\$250	
Dislocation		\$25—\$3,000	
Concussion		\$200	
2nd & 3rd degree burn		\$100—\$10,000	
Internal Injury		\$1,000	
Paralysis (Paraplegia / Quadriplegia)		\$5,000 / \$10,000	
Physical Therapy		\$25	
Blood, Plasma, and Platelets		\$250	
Prosthesis		\$500	
Accidental Death & Dismemberment Benefit			
Primary	\$1,000 - \$50,000	\$1,500 - \$100,000	\$2,000 - \$200,000
Spouse	\$1,000 - \$50,000	\$1,500 - \$100,000	\$2,000 - \$200,000
Child	\$500 - \$25,000	\$750 - \$50,000	\$100 - \$100,000
Monthly Premiums			
Employee Only	\$19.90	\$26.10	\$33.40
Employee + Spouse	\$28.30	\$34.90	\$41.90
Employee + Child(ren)	\$31.50	\$41.00	\$51.30
Family	\$39.90	\$49.80	\$59.90



Critical Illness

Surviving a critical illness, such as a heart attack or stroke, may come at a high price. Although many medical plans provide coverage for costs arising from a critical illness, there are still various out-of-pocket expenses that can affect anyone’s finances. Copayments, transportation, everyday expenditures, and lost income can add up quickly.

Critical Illness insurance can assist with the expenses that may not be covered by traditional medical insurance. The plan is designed to pay a lump sum benefit amount to help cover expenses if you are diagnosed with a covered critical illness.

You have the option to choose the coverage amount that best suits your needs—a lump-sum benefit of \$10,000, \$20,000, or \$30,000. If elected, spousal benefit amounts will be 50% of the employee benefit amount; and children will be eligible for 25% of the employee benefit amount.

You are also eligible to receive a \$50 benefit for a covered health screening test. This benefit features eight qualified tests, including a stress test, echo cardiogram, electrocardiogram (EKG), blood glucose testing, and more.

Covered Illnesses	Benefit Percentage	Recurrent Diagnosis Benefit
Heart Attack	100%	50%
Coronary Artery Bypass Surgery	25%	n/a
Stroke	100%	50%
Paralysis	100%	n/a
Major Organ Failure	100%	50%
End Stage Renal Failure	100%	n/a

Pre-Existing Condition Limitation

No benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months. Pre-Existing Condition means a disease, accident, sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) Treatment
- (b) Incurred expense
- (c) Took medication
- (d) Received care or services including diagnostic testing or related measures
- (e) Received a diagnosis or advice from a Physician

...during the 12-month period immediately before the Covered Person’s Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.



Cancer

Wellness Benefit	Basic	Enhanced	Enhanced Plus
Preventive & Cancer Screening	\$60	\$75	\$90
Treatment Benefits			
Radiation/Chemotherapy	Up to \$15,000	Up to \$20,000	Up to \$25,000
Medical Imaging	\$200	\$300	\$400
Hormone Therapy	\$50	\$50	\$50
Administrative/Lab work	\$75	\$100	\$125
Blood, Plasma, and Platelets	\$150-\$7,500	\$200-\$10,000	\$250-\$12,500
Bone Marrow/Stem Cell Transplant	\$1,000-\$3,000	\$1,500-\$4,500	\$2,000-\$6,000
Hospitalization Benefit			
Hospital Confinement	\$200-\$400	\$300-\$600	\$400-\$800
Drugs & Medicine	\$50-\$200	\$50-\$300	\$500-\$400
Attending Physician	\$40	\$50	\$60
Ambulance, Transportation & Lodging Benefit			
Ambulance (Ground/Air)		\$200/\$2,000	
Transportation		Coach fare or \$0.50/mile by car	
Lodging (per day)	\$60	\$80	\$100
Surgical Treatment Benefit			
Surgical	\$30	\$40	\$50
Anesthesia	25% of the amount paid for covered injury		
Outpatient Hospital/Ambulatory	\$400	\$600	\$800
Second & Third Surgical Opinion	\$300	\$300	\$300
Continuing Care Benefits			
Prosthesis	\$150-\$1,500	\$200-\$2,000	\$250-\$2,500
Extended Care Facility	\$75	\$100	\$125
Physical or Speech Therapy	\$25	\$25	\$25
Hospice Care	\$75	\$100	\$125
Home Health Care	\$75	\$100	\$125
Medical Equipment	\$100	\$150	\$200

Enhance Your Plan

- **Critical Illness rider** pays a lump-sum benefit of \$2,500 when diagnosed with internal cancer or heart attack/stroke.
- **Hospital Intensive Care Unit rider** pays a \$100 ambulance benefit (per admission in an ICU) and \$600 per day up to 30 days for ICU confinement.



EAP & Wellbeing

Employee Assistance Program (EAP)

USD 437 is dedicated to the overall well-being of the employees that choose to provide their time and commitment to the children of the communities that the District serves. We understand that life can provide challenges—at home, at work and within the other circles that we choose to be involved in. USD 437 provides you access to resources available through the Employee Assistance Program (EAP) offered through New Directions, **at no cost to you!**

- **Dedicated Helpline.** 24/7/365 access to licensed behavioral health professionals via a toll-free line.
- **Session Request Tool.** Request for an EAP counseling session with a provider of your choice.
- **Assessments and Referrals.** Receive guidance to the counseling, health plan, legal, financial and community services you need for any life challenges you face.
- **Short-term Counseling.** For life challenges that are not chronic, you and your family can receive up to six counseling sessions for each individual need.
- **Crisis Management Services.** On-site support before, during or after critical situations.
- **Online Tools and Resources.** Anytime, from anywhere, you can access hundreds of resources designed to help you understand, manage and improve your health.
- **Legal and Financial Referrals.** Advice on issues ranging from traffic accidents to debt consolidation.

Access your EAP

Request a counseling session or call into the hotline at **800-624-5544** or log into the website at **www.ndbh.com** > Select for **Individual and Family Members** > Select **Employee Assistance Program** > Enter the Company Code: **AuburnWashburn**.



NEW DIRECTIONS™

Employee Wellbeing Program

The mission of the Employee Wellbeing Program is to encourage, promote, and support wellbeing for every employee, every day. Our vision is to encourage and promote healthy living by providing a caring, supportive environment where healthy behaviors can be modeled, developed, and sustained for staff and students alike. All district employees are eligible to take part in the wellbeing initiatives.

Employee Wellbeing Website: <http://usd437employeewellness.weebly.com>

Wellbeing Programs & Services

- Exercise Prescriptions
- Nutritional Consulting
- Wellness Consulting
- Wellbeing Incentive Challenges
- National Health Observances
- Health Presentations
- Work Station Assessment
- Wellbeing Fair
- District Fitness Options
- Integrated Wellbeing Website



Auburn-Washburn
Employee Wellbeing



403(b) Retirement

USD 437 provides employees the opportunity to invest in a 403(b) account through payroll deductions. Bay Bridge Administrators manage all aspects of the program including monthly remittance, activity monitoring, and compliance. For more information you can access the USD 437 staff website or the BBA website at www.bbadmin.com/retirement > select your state > select your employer. Below is the list of approved investment providers to choose from:

- American Fidelity Assurance Company
- Ameriprise Financial Services
- Aspire Financial Services
- AXA Equitable Life Insurance
- Metropolitan Life Insurance
- Primerica Shareholder Service
- Security Benefit
- Thrivent Financial
- Valic
- Voya Retirement Insurance and Annuity Company
- Waddell and Reed

In order to invest in a 403(b) account you will need to complete a Salary Reduction Agreement (SRA) and/or Election Form. The SRA can be found on the Bay Bridge Administrators website or requested from the Business Office. Current plan participants will receive a personalized election form from the Business Office. See below to determine which forms are necessary for you to complete and return to the Business Office.

- ⇒ Setting up a New Account > Complete a SRA
- ⇒ Existing Account Holder not making changes > Complete Business Office Election Form
- ⇒ Existing Account Holder making changes > Complete Business Office Election Form & SRA



**BAY BRIDGE
ADMINISTRATORS**

*"Your solutions begin
at the Bridge"®*



Legal Notices

Continuation of Health Plan Coverage

A federal law, commonly referred to as COBRA (for Consolidated Omnibus Budget Reconciliation Act) gives you and your covered dependents the right to continue health plan coverage in certain circumstances when it would otherwise end. These include termination of employment or reduction in hours causing loss of plan eligibility of the covered employee, as well as for covered dependents, the death of the covered employee, a divorce or legal separation from the covered employee, or ceasing to be an eligible dependent child of the employee.

It is very important that you notify Human Resources if you experience a divorce/legal separation or have a dependent who no longer meets the eligibility rules of the plan.

If you do not notify Human Resources of one of these events within 60 days, your covered dependents will lose the right to continue their coverage under COBRA. More details are available in the COBRA notification material sent to new health plan participants.

Notice of Special Enrollment Provisions

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after you or your dependents lose eligibility for that other coverage (or employer contributions toward that coverage end). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment, contact your Human Resources Department.

HIPAA Privacy

The USD 437 medical plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by the USD 437 medical plan is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through the Human Resources Department.

Women's Health and Cancer Rights Act of 1998

If you had or are scheduled to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined, in consultation with 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
- Treatment of physical complications during all stages of the mastectomy, including lymphedemas
- Prostheses

These benefits will be provided, subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

Special Rules for Mothers and Newborns

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

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

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



Legal Notices

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

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

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

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>

Phone: 1-800-792-4884

For additional state information or for more information on special enrollment rights, you can contact:

U.S. Department of Labor

Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

Health Insurance Marketplace Coverage Options & Your Health Coverage

Part A: General Information

When key parts of the health care law took effect in 2014, it established 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.

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 for coverage starting as early as January 1st.

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 9.56% 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. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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.



Legal Notices

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources 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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area

PART B: Information About Health Coverage Offered by Your Employer

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

Employer Name:	USD 437 Auburn Washburn
Employer EIN:	48-0722041
Employer Address:	5928 Southwest 53rd St. Topeka, KS 66610
Employer Phone:	(785) 339-4000
Contact Person:	Shannon Elwell elwelsha@usd437.net (785) 339-4014

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

- We offer a health plan to:
 - ◇ 12 month employees regularly scheduled to work four (4) or more hours per day
 - ◇ 9 month employees regularly scheduled to work 28.75 or more hours per week
- We offer coverage to eligible spouses and dependent children to age 26
- This coverage is intended to meet the minimum value standard, and the cost of this coverage to you is meant 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.

Important Notice 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 USD 437 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. BCBSKS has determined that the prescription drug coverage offered by USD 437 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 15 to December 7. 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.



Legal Notices

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 USD 437 coverage will not be affected. You may keep your USD 437 coverage and this plan may coordinate with Part D coverage. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be able to keep these important benefits if you choose to enroll in a Medicare prescription drug plan. If you do decide to join a Medicare drug plan and drop your current USD 437 coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with USD 437 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 19 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 (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 Human Resources at (785) 339-4014. NOTE: You will receive 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 USD 437 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).

A decorative graphic consisting of a dark teal horizontal bar with a vertical line on its right side, and a thin teal arc passing behind it.

“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).”

A decorative graphic consisting of a dark teal horizontal bar with a vertical line on its left side, and a thin teal arc passing behind it.



Contact Information

Carrier Contacts

Blue Cross Blue Shield of Kansas	www.bcbsks.com	800-432-3990
Delta Dental	www.deltadentalks.com	800-234-3375
Superior Vision	www.superiorvision.com	800-507-3800
American Fidelity <i>Flexible Spending Account, Life, Disability, Accident, Critical Illness, & Cancer</i>	www.americanfidelity.com	800-662-1113 Topeka Branch 785-232-8100
Silver Lake Bank (21st & Urish Branch) <i>Health Savings Account</i>	www.silverlakebank.com	785-290-2270
Met Life <i>Life Insurance</i>	www.metlife.com	888-252-3607
New Directions <i>Employee Assistance Program (EAP)</i>	www.ndbh.com Password: AuburnWashburn	800-624-5544
Bay Bridge Administrators <i>403 (b) Retirement</i>	www.bbadmin.com/retirement	800-845-7519

Benefit Consultants

Hays Companies of Kansas	Jessica Cox— jcox@hayscompanies.com	316-448-5113
	Ruth Shank— rshank@hayscompanies.com	316-448-5198

USD 437 Auburn Washburn

Wellbeing & Benefits Coordinator	Shannon Elwell— elwelsha@usd437.net	785-339-4014
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Inspiring, Challenging, and Preparing

EVERY CHILD, EVERY DAY



The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

