Employee Benefits Guide

October 1, 2019 – September 30, 2020

Photo credit: Marching.com

Medical | Dental | Vision | Life | Disability & More

Table of Contents

Please Note: This Benefit Guide is intended to provide a broad overview of your benefits and is presented for informational purposes only. For more detailed information, please refer to the official plan and policy documents available through Human Resources. This Benefit Guide is not intended, nor shall it be construed, as a binding contract. In the case of a discrepancy, the actual plan or policy documents will prevail.

Introduction

We recognize that our employees are our most valuable asset and providing you and your children a competitive and comprehensive benefits package is extremely important to Louisburg School District. It is our pleasure to offer a variety of solutions to help address the needs of our staff and their families.

About This Benefits Guide

This Employee Benefits Guide is intended to provide a broad overview of your benefits and is presented for illustrative purposes only. For more detailed information, please refer to your Certificates of Coverage or Plan Documents available by request through the Benefits Manager. The exact provisions of the Plans may only be determined by reading the actual Plan Documents. In the case of a discrepancy, the actual plan documents or insurance carrier contracts will prevail.

Please note that Louisburg reserves the right to modify and/or discontinue the benefits it provides, premium amounts it pays, eligibility rules, and other provisions of these benefit plans, for any reason. When possible, we will notify you in advance of such changes or additions.

Employee Benefits Eligibility

Full-time employees that are regularly scheduled to work at least 30 hours per week or more are eligible for all benefits. Other employees regularly scheduled to work at least 20-29 hours per week are eligible for all benefits except medical. Coverage is effective on the first of the month following 60 days of employment for custodian and food service employees and first of the month following date of hire for all other employees.

Dependent Benefits Eligibility

For medical coverage, eligible family members include your children up to age 26. Adult dependent children are eligible to participate in the medical plan until the end of the month in which they turn age 26.

For dental and vision, eligible family members include your legal spouse and children up to age 26. Adult dependent children are covered on these plans until the end of the month in which they turn 26.

Voluntary life coverage is available to spouses and children to age 19, or to age 25 for full-time students.

Changing Coverage During the Year

Once you elect your benefits, you can only change your elections at the next annual open enrollment period unless you experience a qualifying life change like the ones listed below:

- Marriage
- Birth or adoption
- Divorce or legal separation
- Spouse Open Enrollment
- A loss or gain of coverage or eligibility
- Job loss or reduction in work hours
- Medical Child Support Order
- Death of a dependent
- Change in Medicaid/CHIP Status
- Entitlement to Medicare

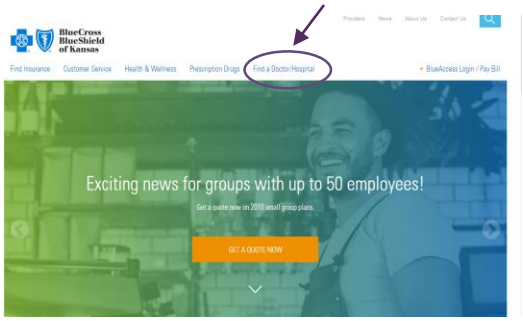
Changes must be made within 30 days of the qualified event. If changes are not made during that time, you will need to wait until the next open enrollment period to change your benefits. To make a change due to a qualified life change event, please contact Human Resources.

About Your Medical Plan Options

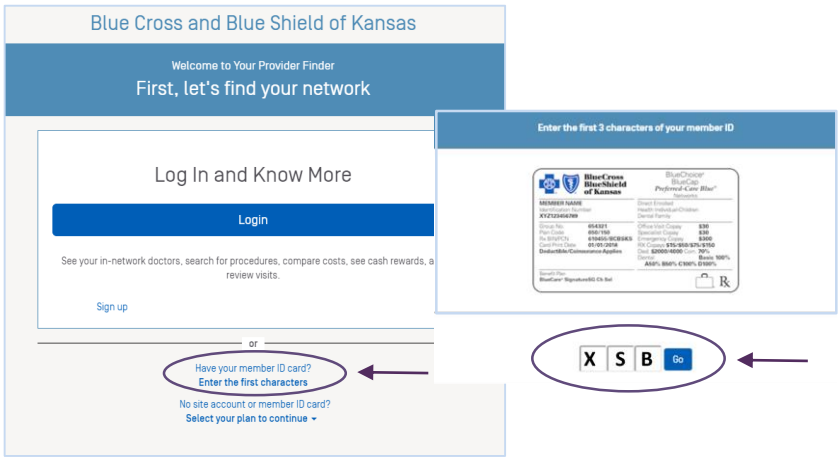
Our health plan is administered by Blue Cross and Blue Shield of Kansas using the Blue Choice network. You may use the health care provider of your choice, however you will receive greater benefits by seeing a participating network provider. The medical plans offered through Louisburg School District allow employees to choose from two different options administered through Blue Cross and Blue Shield of Kansas, a traditional PPO and a High Deductible Health Plan (HDHP) with Health Savings Account (HSA).

How to Search for a Network Provider

Step 1 – Go to www.bcbsks.com and click on the "Find a Doctor" tab and on the next screen select "Find a Doctor/Hospital".

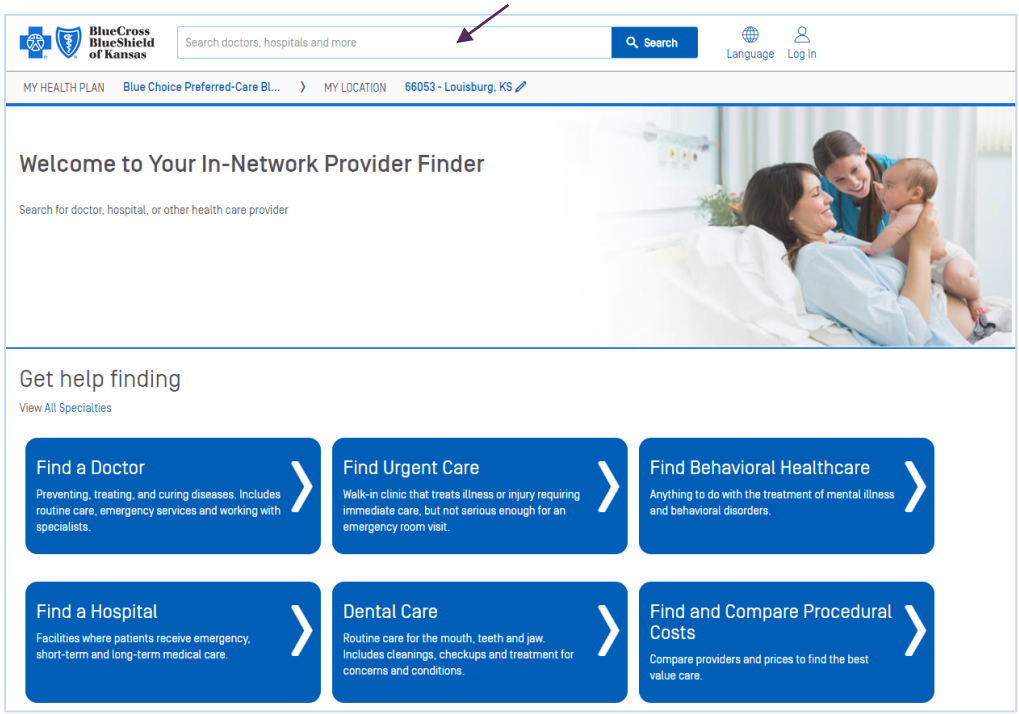


Step 2 – Click on "Enter the first characters", then type in "XSB".



Step 3 – Now you can type in the name of a provider in the search bar or click on the type of provider you are looking for.

You may also call customer service at (800) 432-3990 for additional assistance.



BlueCross BlueShield of Kansas

Medical Plans At-A-Glance

** In-network benefits shown for illustrative purposes only*

Medical Benefits	Plan Option #1: PPO Plan	Plan Option #2: High Deductible Plan
Annual Deductible (deductibles are embedded)	Individual - $500 Two or More Persons - $1,000	Individual - $3,000 Two or More Persons - $6,000
Coinsurance (% plan pays after you meet the deductible)	80%	100%
Coinsurance Maximum (maximum amount of coinsurance you pay after you meet the deductible)	Individual - $2,500 Two or More Persons - $5,000	n/a
Total Deductible + Coinsurance	Individual - $3,000 Two or More Persons - $6,000	Individual - $3,000 Two or More Persons - $6,000
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	Individual - $5,000 Two or More Persons - $10,000	Individual - $6,350 Two or More Persons - $12,700
Routine Preventive Care	Covered 100%	Covered 100%
Office Visit – Primary Care & Specialist	$35 Copay	Deductible
Office Visit – Chiropractic (no visit limitation)	$35 Copay	Deductible
Telehealth Consultation (AmWell)	$35 Copay	$49 Consultation Fee
Urgent Care	$35 Copay	Deductible
Emergency Room	$100 Copay then Deductible + 20%	Deductible
Accidental Injury Services	Plan Pays 100% up to $1,000; then Deductible + 20%	Deductible
Outpatient Short Term Therapy (PT, OT, etc)	$35 Copay	Deductible
Outpatient Lab & Radiology (includes advanced imaging)	Plan Pays 100% to a combined maximum of $300; then Deductible + 20%	Deductible
Inpatient / Outpatient Services	Deductible + 20%	Deductible
Prescription Drug Benefits	**Retail (30-day supply)**	**Retail (30-day supply)**
Tier 1 – Generic	$15 Copay	Deductible then $15 Copay
Tier 2 – Preferred Brand	$30 Copay	Deductible then $50 Copay
Tier 3 – Non-Preferred Brand	$45 Copay	Deductible then $75 Copay

This summary outlines the highlights of your plan. For a complete list of both covered and non-covered services see the summary plan description -- the official plan document.

Monthly Premium Cost

Medical / Rx	Plan Option #1: PPO Plan	Plan Option #2: High Deductible Plan
Employee Only	$93.69	$18.26
Employee + 1 Child	$498.74	$367.11
Employee + 2 or More Children	$1,090.23	$875.64

BlueCross BlueShield of Kansas

Plan Option #1: PPO Plan

Medical Benefits	In-Network	Out-of-Network
Annual Year Deductible (deductibles are embedded)	Individual - $500 Two or More Persons - $1,000	Individual - $500 Two or More Persons - $1,000
Coinsurance (% cost sharing after you meet the deductible)	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Coinsurance Maximum (maximum amount of coinsurance you pay after you meet the deductible)	Individual - $2,500 Two or More Persons - $5,000	Individual - $4,500 Two or More Persons - $9,000
Total Deductible + Coinsurance	Individual - $3,000 Two or More Persons - $6,000	Individual - $3,000 Two or More Persons - $6,000
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	Individual - $5,000 Two or More Persons - $10,000	Individual - $7,000 Two or More Persons - $14,000
Routine Preventive Care	Covered 100%	Covered 100%
Office Visit – Primary Care & Specialist	$35 Copay	Deductible + 40%
Office visit – Chiropractic (no visit limitation)	$35 Copay	$35 Copay
Telehealth Consultation	$35 Copay	$35 Copay
Urgent Care	$35 Copay	Deductible + 40%
Emergency Room	$100 Copay then Deductible + 20%	
Accidental Injury Services	Plan Pays 100% up to $1,000; then Deductible + 20%	
Outpatient Short Term Therapy (PT, OT, etc)	$35 Copay	Deductible + 20%
Outpatient Lab & Radiology (includes advanced imaging)	Plan Pays 100% to a combined maximum of $300; then Deductible + 20%	
Inpatient / Outpatient Services	Deductible + 20%	Deductible + 40%
Prescription Drug Benefits	**Retail (30-day supply)**	**Mail Order (90-day supply)**
Tier 1 – Generic	$15 Copay	$37.50 Copay
Tier 2 – Preferred Brand	$30 Copay	$75 Copay
Tier 3 – Non-Preferred Brand	$45 Copay	$112.50 Copay

This summary outlines the highlights of your plan. For a complete list of both covered and non-covered services see the summary plan description -- the official plan document.

Here is information to help you understand how this plan works:

Copay - A flat fee you pay for certain covered services, such as doctor's office visits and prescription drugs. Medical and prescription drug copays do not apply to towards the deductible but do accumulate toward the out-of-pocket maximum.

Annual Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services. Deductibles accumulate toward the out-of-pocket maximum and reset each year on October 1st.

Coinsurance - After you've reached your deductible, you and the plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Coinsurance Maximum – This is the most you will pay out-of-pocket for coinsurance and will reset each year on October 1st.

Out-of-Pocket Maximum – This is the maximum amount you will pay out of your own pocket for all covered services. Medical and prescription drug copays, deductibles and coinsurance amounts all accumulate toward your out-of-pocket maximum which will reset each year on October 1st. Once the out-of-pocket maximum has been reached, the plan will pay 100% for covered services.

BlueCross BlueShield of Kansas

Plan Option #2: High Deductible Plan w/ HSA

Medical Benefits	In-Network	Out-of-Network
Annual Year Deductible (Deductibles are embedded)	Individual - $3,000 Two or More Persons - $6,000	Individual - $3,000 Two or More Persons - $6,000
Coinsurance (% Cost Sharing After You Meet the Deductible)	Plan Pays 100% You Pay 0%	Plan Pays 80% You Pay 20%
Coinsurance Maximum (maximum amount of coinsurance you pay after you meet the deductible)	n/a	n/a
Total Deductible + Coinsurance	Individual - $3,000 Two or More Persons - $6,000	Individual - $3,000 Two or More Persons - $6,000
Annual Out-of-Pocket Maximum (Includes deductible, coinsurance & copays)	Individual - $6,350 Family - $12,700	Individual - $8,350 Family - $16,700
Routine Preventive Care	Covered 100%	Covered 20%
Office Visit – Primary Care & Specialist	Deductible Only	Deductible + 20%
Office visit – Chiropractic (no visit limitation)	Deductible Only	Deductible + 20%
Telehealth Consultation (AmWell)	$49 Consultation Fee	$49 Consultation Fee
Urgent Care	Deductible Only	Deductible + 20%
Emergency Room	Deductible Only	Deductible 20%
Accidental Injury Services	Deductible Only	Deductible 20%
Outpatient Short Term Therapy (PT, OT, etc)	Deductible Only	Deductible + 20%
Outpatient Lab & Radiology (includes advanced imaging)	Deductible Only	Deductible + 20%
Inpatient / Outpatient Services	Deductible Only	Deductible + 20%
Prescription Drug Benefits	**Retail (30-day supply)**	**Mail Order (90-day supply)**
Tier 1 – Generic	Deductible + $15 Copay	$37.50 Copay
Tier 2 – Preferred Brand	Deductible + $30 Copay	$75 Copay
Tier 3 – Non-Preferred Brand	Deductible + $45 Copay	$112.50 Copay

This summary outlines the highlights of your plan. For a complete list of both covered and non-covered services see the summary plan description -- the official plan document.

Here is information to help you understand how this plan works:

Annual Deductible – You are responsible for the cost of all covered services until you meet your deductible. A deductible is the dollar amount you must pay out of your own pocket before your plan begins to pay for covered services. Deductibles accumulate toward the out-of-pocket maximum and reset each year on October 1st.

Coinsurance - After you've reached your deductible, you and the plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance. This plan only has coinsurance for non-network services.

Copay – Once the plan deductible has been met, prescription drugs can be obtained at a flat fee copay. These prescription drug copays will apply toward the out-of-pocket maximum.

Out-of-Pocket Maximum – This is the maximum amount you will pay out of your own pocket for all covered services. Medical and prescription drug copays, deductibles and coinsurance amounts all accumulate toward your out-of-pocket maximum which will reset each year on October 1st. Once the out-of-pocket maximum has been reached, the plan will pay 100% for covered services.

Telehealth Benefits

Telehealth provides employees 24/7/365 access to health care services that is an affordable and convenient alternative to urgent care and emergency room visits. BCBSKS has partnered with American Well (Amwell) to bring you care from the comfort and convenience of your own home, or wherever you are, by using your smart phone or web browser. Amwell lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office.

When to Use Telehealth

Telemedicine services can be used instead of going to the doctor's office, urgent care clinic or emergency room for common non-life threatening conditions. You can also get lab results analyzed, get answers to your health-related questions or need a short-term prescription refilled. Here are some of the medical issues they can help with:

- ✓ cold / flu / fever
- ✓ cough / sore throat
- ✓ upper respiratory infections
- ✓ headache
- ✓ asthma / allergies
- ✓ ear / sinus infections
- ✓ acid reflux / indigestion
- ✓ nausea / stomach virus
- ✓ constipation
- ✓ skin rashes
- ✓ pink eye
- ✓ urinary tract infections

For more information, visit bcbsks.com/telehealth or call 844-SEE-DOCS

How to Get Started

1. **Download the Amwell Mobile App**. The Amwell app can be downloaded directly to your smart phone or tablet. You can also register on bcbsks.com/telehealth.
2. **Enroll**. Open the Amwell app and click Sign Up. Complete your profile and agree to Terms of Use. Be sure to include your BCBSKS insurance information when setting up your profile.
3. **Choose a Doctor**. View a list of available doctors and select one.
4. **Visit**. Engage in a secure live video visit directly from the web or your mobile device in high-quality streaming video.

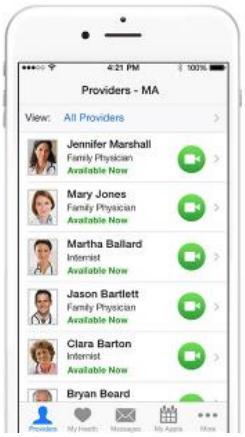
The cost of telehealth visits are:

1. ***$35 Copay for PPO Members***
2. ***$49 Consultation Fee for HDHP Members***

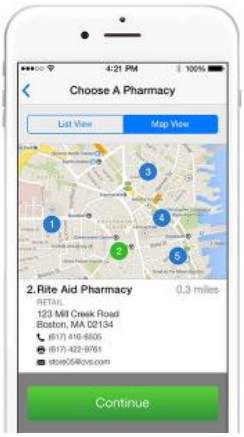
What to expect during your visit

What to expect during your visits: Most doctor visits take about 10 minutes, but you can always add time if you need to. Doctors on Amwell® can review your history, answer questions, diagnose, treat and even prescribe medication. Prescriptions will be sent to your pharmacy of choice.

Review Available Doctors



Choose Your Pharmacy



Start Your Video Visit

BlueCross BlueShield of Kansas

Choosing the Right Health Care Setting

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. The chart below can help you select the right setting for your needs:

	Primary Care Provider	Walk-in Clinic	Telehealth/ Amwell	Urgent Care Center	Emergency Room
Mild Asthma	⊙	⊙	⊙	⊙	
Minor Headaches	⊙	⊙	⊙	⊙	
Sprains, Strains	⊙	⊙	⊙	⊙	
Nausea, Vomiting, Diarrhea	⊙	⊙	⊙	⊙	
Bumps, Cuts, Scrapes	⊙	⊙	⊙	⊙	
Burning with Urination	⊙	⊙	⊙	⊙	
Coughs, Sore Throat	⊙	⊙	⊙	⊙	
Ear and Sinus Pain	⊙	⊙	⊙	⊙	
Eye Swelling, Irritation, Redness or Pain	⊙	⊙	⊙	⊙	
Minor Allergic Reactions	⊙	⊙	⊙	⊙	
Minor Fevers, Colds	⊙	⊙	⊙	⊙	
Rashes, Minor Burns	⊙	⊙	⊙	⊙	
Vaccinations	⊙	⊙		⊙	
Animal Bites				⊙	
Stitches				⊙	
X-rays				⊙	
Back Pain	⊙			⊙	
Any life-threatening or disabling condition including difficulty breathing					⊙
Sudden or unexplained loss of consciousness					⊙
Chest pain, numbness in face, arm or leg; difficulty speaking					⊙
Severe shortness of breath					⊙
High fever with stiff neck, mental confusion or difficulty breathing					⊙
Coughing up or vomiting blood					⊙
Cut or wound that won't stop bleeding					⊙
Major Injuries					⊙
Possible Broken Bones					⊙

BlueCross BlueShield of Kansas

Routine Preventive Services

Both of our health plans offer Routine Preventive Care Services that are covered at 100% in-network. Early diagnosis is the key in treating potentially serious health conditions. Rather than treating a condition after it has progressed, maintain your good health by getting your annual routine wellness exam. X-rays, blood tests and other routine screenings are the best way to detect the early warning signs.

Below is a list of just some of the Routine Preventive Care Services covered at 100% in-network. Some age and frequency limitations may apply. For a complete listing of Routine Preventive Services and age/frequency limitations, go to www.bcbsks.com/aca.

Preventive Services for Adults

- Abdominal aortic aneurysm screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening for adults
- Type 2 diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- Hepatitis C virus infection screening for adults at higher risk
- HIV screening for all adults at higher risk
- Immunization vaccines for adults – doses, recommended ages, and recommended populations vary
- Obesity screening and counseling for all adults
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Vitamin D for adults 65 years of age and older

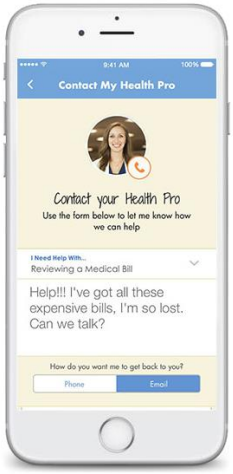
Preventive Services for Children

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and body mass index measurements for children
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary
- Iron supplements for children six to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- One vision screening for all children under the age of 5

Your Personal Healthcare Navigator

Louisburg USD 416 has partnered with Compass to serve as your personal healthcare advisor. Your Health Pro at Compass will help you navigate through the complexities of the healthcare system to find the right doctor, confirm insurance coverage, provide cost estimates, schedule appointments, and resolve billing questions.

Download the Health Pro Cloud app so you can access your Health Pro consultant using your mobile device!



Health Pro Cloud is an iOS and Android app.

Download on the App Store | ANDROID APP ON Google play

Transparency Cost Estimate

Before you get services done, contact Compass to obtain cost estimates for you! This not only will help you save money, but it will help to keep our plan costs down so we can continue offering affordable health coverage. Your Compass Health Pro will provide you a cost estimate BEFORE you get that service or procedure done. Knowing your options will allow you to make the most informed and cost effective decision possible.

Here's an example of an actual cost estimate for an Endoscopy:

UPPER GI ENDOSCOPY - LENEXA, KS MARKET ANALYSIS		
Option	Location	Rate
A	Shawnee Mission Medical Center	$2,675
B	Overland Park Surgery Center	$2,510
C	Endoscopic Imaging Center	$1,490*
*Total Savings of $1,185 could be achieved between a high-cost and low-costfacility		

Health Savings Account

What is a Health Savings Account?

This is an individually-owned, tax-advantaged account used to pay for eligible out-of-pocket health care expenses (i.e. medical, dental, vision, prescription drug). In order to participate, you must be enrolled in a Qualified High Deductible Health Plan (QHDHP) like Louisburg's High Deductible health plan. You cannot contribute to an HSA if you are covered by a non-QHDHP such as a PPO plan with copays or if you are covered as a dependent on someone else's tax return.

How Does an HSA Work?

You may contribute to your Health Savings Account through payroll deductions on a pre-tax basis. **If you choose to contribute to an HSA, the minimum contribution through payroll deduction is $25 per month**. Annual maximum contribution limits are set each year by the IRS and are illustrated below.

HSA Maximum Annual Contribution			
CALENDAR YEAR	EE ONLY COVERAGE	EE + CHILD(REN) COVERAGE	"CATCH-UP" CONTRIBUTION (Age 55 or older)
2019	$3,500	$7,000	$1,000
2020	$3,550	$7,100	$1,000

For HSA accountholders age 55 and older, an additional $1,000 annual "catch up" contribution is allowed each year.

Remember: You are responsible for ensuring that you are eligible to contribute to an HSA and for ensuring that the total contribution amounts do not exceed the IRS maximum annual contributions and that you are eligible to contribute to an HSA.

How to Use Your HSA Funds

Using your HSA funds is easy. The First Option Bank debit card conveniently allows you to pay for eligible expenses using the funds in your HSA.

Here is how it works:

- When you need to pay for healthcare expenses, you can simply present the card to an eligible provider that accepts the Visa® debit card .
- Your HSA funds can be used to pay for a variety of healthcare-related expenses and are tax-free as long as they are used to pay for qualified medical expenses.
- With the swipe of the card, the payment is automatically deducted from your HSA balance. As long as you have the necessary funds in your account, there's no need to pay for healthcare expenses out of pocket, and no need to submit manual reimbursement requests.
- The IRS does require you to keep your receipts for up to 5 years in the event you are audited.

Remember, unlike the Flexible Spending Account, ***the funds in your HSA do rollover from year to year*** and your account goes with you if you leave the district!

First Option Bank

After you enroll, you will receive your account number and debit card in the mail within 5-7 business days. Once you receive it, go to www.firstoptionbank.com and click "Sign up for your online account". You will need your account number and debit card number to set up your user name and password.

Online access will allow you to view your account balance, reimburse yourself for medical expenses incurred without the debit card, download forms, pay providers, and access a variety of other resources and tools to help you manage your HSA, including investment options.

Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

A Flexible Spending Account (FSA) is an account in which you set aside pre-tax dollars to pay for eligible health care or dependent care expenses not covered by insurance. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax. You can participate in any or all of the following accounts:

Health Care FSA: You may elect an amount up to **$2,700** per plan year to be used for health, dental and vision expenses for you and eligible dependents. Some eligible expenses include (but are not limited to) the following:

- Medical or Dental Deductibles and Coinsurance
- Office Visit and Prescription Drug Copays
- Orthodontia and Other Dental Work
- Eyeglasses and Contact Lenses
- Laser Eye Surgery
- Hearing Aids

Limited-Purpose Health Care FSA: This plan is for those enrolled in the HDHP plan (with an HSA) and can only be used for non-medical expenses such as dental, vision, and orthodontia expenses. You may elect an amount up to **$2,700** per plan year.

Dependent Care FSA: You may elect an amount up to **$5,000** per plan year ($2,500 maximum per year if married and filing a separate tax return) and can be used for child care for dependents under age 13, elder care, or care for a disabled child as long as expenses are incurred while you and your spouse work or attend school full time. Some eligible expenses include (but are not limited to) the following:

- Child Daycare
- Before and/or After School Care
- Adult Day Care for Seniors
- Summer Camp

How Does an FSA Work?

By setting aside pre-tax dollars to pay for out-of-pocket expenses you would normally pay for using after-tax dollars, you are reducing your "taxable income" because it reduces the amount of federal, state and FICA taxes you pay. This means more take-home pay for you!

Your contributions are taken pre-tax and divided equally among your pay periods. Funds can be used for expenses incurred from October 1, 2019 through September 30, 2020. You then have 60 days at the end of the plan year to submit your claims and receipts for reimbursement.

The IRS imposes some rules and restrictions on the way you can use FSAs. ***Any and all unused Health Care and Dependent Care FSA funds left in the account at the end of the plan year will be forfeited.*** For additional rules and restrictions, please call Flex Made Easy at (877) 523-0176, or send an email to info@FlexMadeEasy.com.

Flexible Spending Accounts

How Do I Use the Funds in my FSA?

There are two different ways you can use the funds in your FSA.

1. You can use the Benefit Card instead of your own cash or credit cards to pay for eligible expenses. When you use the Benny Card, the amount of the expense is deducted from your account balance at the time of purchase.

   Most expenses will auto substantiate, meaning the merchants system will provide the necessary information to Flex Made Easy so that you don't have to send in an itemized receipts. If your purchase is not auto substantiated, Flex Made Easy will send you a letter or email requesting an itemized receipt to verify that you purchased was an eligible item or service. For this reason, and because the IRS requires it, you need to keep receipts for all purchases made using FSA funds.

   Another way to use the Benefit Card is by writing the card number on the back of the "balance due" notices you receive from hospitals, doctors, dentists or vision providers.

2. You may also pay for your expenses up front using your own cash or credit cards and reimburse yourself by submitting a paper claim form. Completed claim forms and itemized receipts can be mailed, emailed, faxed or uploaded through a mobile app using a smartphone to Flex Made Easy. Reimbursements would then come to you in the form of either a check or direct deposit.

Managing Your FSA

Flex Made Easy enables you to easily and securely access your Flexible Spending Accounts online, using a smartphone, or through a mobile device. Here are some of the ways you can manage your FSA using the Flex Made Easy secure online portal and mobile app:

- ✓ Check your current Health Care and Dependent Care account balances
- ✓ View account activity and transaction details
- ✓ File claims
- ✓ Upload pictures of a receipt using your mobile device's camera
- ✓ Receive text alerts

Questions?

If you have specific questions, you may contact:

Flex Made Easy
Email: info@FlexMadeEasy.com
Phone: (855) 615-3679

or

Benefits-Direct
Email: info@benefits-direct.com
Phone: (877) 523-0176.

Dental

About Your Dental Plan

Louisburg offers a comprehensive dental plan through Blue Cross Blue Shield of Kansas with a national network of providers through the Kansas Dental Grid+ network. You may use the dental provider of your choice, however Blue Cross and Blue Shield network providers have agreed to considerably discount their services so you pay less out of pocket. You will receive greater benefits by seeing a Kansas Dental Grid+ provider.

Search for a Provider: To search for a Participating network provider, go to **www.bcbsks.com** and select "Dental Provider" under the "Find a Doctor" tab. You can type in the name of your dentist, or you can input your zip code to find all the network providers in your area. Providers that are designated as Grid Plus are in-network. You may also call customer service at **(800) 432-3990** for additional assistance.

Going Out-of-Network: If you use an out-of-network provider, your out-of-pocket expenses will be higher than if you used an in-network provider because the provider can balance bill you for the difference between what Blue Cross and Blue Shield pays and the provider's normal charge.

Dental Benefits	In-Network	Non-Network
Calendar Year Deductible	$25 per Person $75 per Family Limit	$25 per Person $75 per Family Limit
Diagnostic/Preventive Services *(exams, cleanings, x-rays, sealants)*	Plan Pays 100% (deductible waived)	Plan Pays 100% (deductible waived)
Basic Services *(fillings, simple extractions, anesthesia)*	Plan Pays 80%	Plan Pays 80%
Major Services *(oral surgery, root canals, crowns, bridges, dentures)*	Plan Pays 50%	Plan Pays 50%
Calendar Year Maximum Benefit	$1,500 per Person	
Implants	Covered up to $1,000 per Arch per Lifetime	
Orthodontia *(for children under age 21)*	100% payment subject to the following maximums: • Active Treatment: $750 annual maximum up to $1,500 over 3 years • Diagnosis (study models and facial photos): $150 (5 year period) • Retention Treatment (retainers): $150 (18 month period)"	

Monthly Premium Cost

Monthly Dental Premiums	
Employee Only	$30.86
Employee + Spouse	$66.17
Employee + Child(ren)	$66.60
Family	$101.22

About Your Vision Plan Options

Louisburg offers two different vision plans from which to choose. Below, there is information about how each plan works so you can make a decision as to which plan is the best fit for your situation.

Vision Care Direct

Through Vision Care Direct, you can choose from two plans. It is important to know that these plans are in-network only plans, so you must use a VCD provider to receive benefits. Here are some local providers that only accept VCD insurance plans:

- Andrew Hill
- Whitesell Optometry
- Drs. Price, Young, Odle and Horsch
- Eyecare Professionals

To Search for Other Network Providers: To search for a Participating network provider, go to visioncaredirect.com and search using your zip code or Doctor. You may also call customer service at 1-877-488-8900.

Vision Care Direct Benefits		
	Silver Plan	Gold Plan
Eye Exams	**$15 Copay** Every 12 Months	**$10 Copay** Every 12 Months
Standard Eyeglass Lenses	**$15 Copay** Every 12 Months	**$15 Copay** Every 12 Months
Frames	**$130 Allowance** Every 24 Months	**$130 Allowance** ***Every 12 Months***
Contact Lenses	**$160 Allowance** Every 12 Months	**$130 Allowance** Every 12 Months

VCD Monthly Vision Premiums		
	Silver Plan	Gold Plan
Employee Only	$12.60	$15.22
Employee + Spouse	$20.16	$24.36
Employee + Child(ren)	$23.26	$28.10
Family	$39.56	$47.78

Surency

The Surency plan uses the EyeMed Access national network and allows you go to an independent private practice location or to select retail chain locations for your exams and materials.

The plan also has some out-of-network allowances, however they are quite minimal. If your provider is out-of-network, it would be wise to evaluate whether the out-of-network benefits outweigh the annual premium cost.

To Search for a Provider: To search for a participating Access network provider, go to Surency.com and search using the Surency Vision Mobile App. You may also call customer service at (866) 818-8805.

Surency Vision Benefits		
	In-Network	*Out-of-Network*
Eye Exams	**$10 Copay** Every 12 Months	*$35 Allowance* *Every 12 Months*
Standard Eyeglass Lenses	**$15 Copay** Every 12 Months	*$25-$55 Allowance* *Every 12 Months*
Frames	**$130 Allowance** Every 24 Months	*$65 Allowance* *Every 24 Months*
Contact Lenses	**$130 Allowance** Every 12 Months	*$40 Allowance* *Every 12 Months*

Surency Monthly Vision Premiums	
Employee Only	$8.00
Employee + Spouse	$16.78
Employee + Child(ren)	$14.40
Family	$29.93

Additional Benefits

Louisburg School District offers supplemental insurance options to you and your family through BenefitsDirect. These benefit plans are voluntary which means the cost for these benefits are fully funded by you. A representative from BenefitDirect will help walk you through all of your options so you can make informed decisions.

Group Term Life Insurance

RELIANCE STANDARD LIFE INSURANCE COMPANY

You have the opportunity to purchase additional life insurance for yourself or your spouse and children through Reliance Standard. Employee and Spouse coverage is available in amounts from $10,000 to a maximum of $500,000 (in $10,000 increments). Child coverage is available in the amount of $10,000 for children age 6 months to 20 years of age (26, if full-time student). The benefit amount for children age14 days to 6 months is $1,000.

Short Term Disability

RELIANCE STANDARD LIFE INSURANCE COMPANY

Disability insurance provides some income replacement should you become disabled and unable to work due to a non-work related injury or illness. This plan, through Reliance Standard, offers you choices of how much of a benefit you receive, when you begin receiving it, and for how long you receive that benefit.

Benefit Amount: You may elect a weekly benefit in increments of $25, from a minimum of $100 up to a maximum benefit of $1,700 per week, not to exceed 66 2/3 % of your covered earnings (round to the next lower increment).

Your Options: Benefits will begin after the elimination period (the time you must remain disabled) has been satisfied. Benefits will continue to be paid as long as you are disabled.

- Option 1: Injury/Accident = 1st Day; Sickness/Illness = 8th Day; payable for up to 26 weeks
- Option 2: Injury/Accident or Sickness/Illness = 15th Day; payable for up to 24 weeks
- Option 3: Injury/Accident or Sickness/Illness = 31st Day; payable for up to 22 weeks

Hospital Indemnity

RELIANCE STANDARD LIFE INSURANCE COMPANY

This plan is offered to help cover the costs of hospital stays, whether expected or unexpected. There are no pre-existing condition limitations, no medical exams required, and benefits are paid directly to you. For a hospital admission, the benefits is $1,000. Then, you could receive $100 a day for room and board for up to 180 days per calendar year. If you are admitted and stay in a Critical Care Unit, you could receive an additional $100 per day benefit for up to 30 days per calendar year.

Accident Insurance

PROSPERITY℠

Accidents can happen at any moment, and when we least expect it. Purchasing an Accident plan for yourself, your spouse and/or your children can help ease the worry of unexpected expenses arising from a covered accident. This plan, offered through Manhattan Life Insurance Company, would provide lump sum benefits for things like fractures, dislocations, emergency room charges, ambulance rides and hospital stays as a way to help you with out-of-pocket medical expenses (e.g. deductibles, copays, coinsurance). There are two levels of coverage from which to choose.

BenefitsDirect
An AMERILIFE BENEFITS Company

Permanent Term Life & Long Term Care

COMBINED INSURANCE

This policy provides the protection of two policies in one through Combined Insurance Company. The Permanent Term Life insurance has premiums that are guaranteed for Life. The Long Term Care benefit is worth three times your death benefit amount elected, which can be used to pay for Nursing Home or Assisted Living care facilities. Guaranteed acceptance coverage is available up to $75,000.

Critical Illness Insurance

PROSPERITY℠

Being diagnosed with a serious condition or experiencing a critical medical event can bring unexpected medical expenses that you and your family weren't planning on. The Critical Illness policy provides a lump-sum benefit for covered illnesses like heart attacks, strokes, transplants, renal failure, angioplasty, and severe burns. You may select levels of coverage from $5,000 to $50,000 and there are optional policy riders you can add, such as Cancer and First Occurrence benefits.

Identity Theft Protection

INFOARMOR
DETECTION IS THE NEW PREVENTION

InfoArmor's Identity Theft insurance policy protects against financial damages as a result of identity theft such as legal defense expenses and lost wages. InfoArmor not only helps to resolve identity theft after it occurs, but they proactively monitor your identity and alert you to any activity (e.g. when a new bank account is opened in your name, or if an application for a new credit card was made). You not only have the opportunity to purchase this protection for yourself, but for your family too!

MetLaw

Smart. Simple. Affordable.®
Hyatt Legal Plans
A MetLife Company

With MetLaw, you, your spouse and children can receive fully covered legal services for a wide range of personal legal matters. There are no deductibles or copays, no waiting periods or claim forms and no limits on usage!

Legal Issues Covered by the Plan

- Consumer Protection Matters (small claims court)
- Defense of Civil Lawsuits
- Document Preparation & Review
- Elder Law Matters
- Estate Planning Documents
- Family Law (adoption, guardianship, name change, prenuptial)
- Financial Matters (debt collection, foreclosure, credit negotiations, bankruptcy, tax audit)
- Identity Theft Matters
- Immigration Assistance
- Juvenile Matters (juvenile court defense, parental responsibility)
- Traffic Matters (traffic tickets, DUI, license suspension)
- Personal Property Protection
- Real Estate Matters (boundary disputes, eviction/tenant problems, sale/purchase/refinancing, zoning applications

GENERATION:	COMMON FINANCIAL LEGAL ISSUES:	COMMON PERSONAL LEGAL ISSUES:
Millennials (18 - 34)	Credit Card Debt, Debt Collection Defense	Traffic Tickets, Purchase of a Home or Condo, Landlord Negotiations
Gen X (35 - 50)	Foreclosure, Refinancing, Estate Planning	Adoption, School Hearing, Will Preparation, Trusts
Baby Boomers (51 - 69)	Tax Audits, Property Sale, Identity Theft	Powers of Attorney, Living Wills, Medicare questions
Traditionalists (70+)	Property Sale, Nursing Home/Assisted Living Agreements, Leases, Deeds	Powers of Attorney, Wills, Living Wills, Medicare/ Medicaid questions, Prescription Plan questions

Important Contacts

BenefitsDirect

Louisburg School District partners with BenefitsDirect to bring you quality voluntary benefit solutions and a personalized enrollment experience. They are a resource for employees to use when enrolling in benefits, and making changes to benefits as life events occur. Their Customer Advocate Center is staffed with experts that will help answer questions about claims, provider networks, and plan coverage. Here is how to contact BenefitsDirect:

Phone: (877) 523-0176
Email: info@benefits-direct.com
Online: www.benefits-direct.com/LouisburgUSD416

Other Contacts and Resources

Plan/Program	Vendor	Ways to Contact
Patient Advocacy	Compass	(800) 513-1667 www.member.compassphs.com
Medical / Rx	Blue Cross and Blue Shield of Kansas Policy Number: 181634211	(800) 432-3990 www.bcbsks.com
Health Savings Account	First Option Bank	(913) 837-3900 www.firstoptionbank.com
Dental	Blue Cross and Blue Shield of Kansas Policy Number: 181634211	(800) 432-3990 www.bcbsks.com
Vision	Vision Care Direct Policy Number: 3564 Surency Policy Number: 06002-000-00019	(877) 488-8900 www.visioncaredirect.com (316) 462-3393. www.surency.com
Flexible Spending Accounts	Flex Made Easy	(855) 615-3679 www.flexmadeeasy.com
Identity theft protection	InfoArmor Group Number: 650	(800) 789-2720 wwww.infoarmor.com
MetLaw	Hyatt Legal Group Number: 940010	(800) 821-6400 www.metlife.com/mybenefits
Vision, FSA, Identity Theft and Voluntary Benefits	BenefitsDirect	(877) 523-0176 www.benefits-direct.com

Legal Notices

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). You must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding your or your dependents' other coverage on your initial enrollment form/waiver.

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. You must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

You may also be eligible for a Special Enrollment Period if you and/or your dependents are determined to be eligible for premium assistance under a state Medicaid plan or state child health plan. You must request enrollment within 60 days of the date you are determined to be eligible for this premium assistance.

Women's Health and Cancer Rights Act

If you had or are going 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:

1. All states of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all states of the mastectomy, including lymphedemas.

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

Newborns and Mothers Health Protection Act

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

Notice of Availability of HIPAA Privacy Notice

Under the Health Insurance Portability and Accountability Act (HIPAA), health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plans' responsibilities.

HIPAA requires we advise you that a copy of the Privacy Notice is available by contacting the Benefits Manager and requesting a hard copy.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Since 2014, there is now a new way to buy health insurance: the Health Insurance Marketplace. To assist you with evaluating the 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 for coverage purchased through the Marketplace. 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 9.86% of your household income for 2019 (9.76% in 2020), 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 usually excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace would be made on an after-tax basis.*

How Can I Get More Information on my Employer's Health Coverage?

Please read the next page for more information you'll need if you decide to shop for coverage on the Marketplace. For additional information about your employer-sponsored health coverage, please contact the Benefits Manager.

How Can I Get More Information on the Marketplace?

The Marketplace will consist of state-specific websites where you can compare health insurance options available where you live. Some states have created their own Marketplace, while others will be using sites run by the U.S. Department of Health and Human Services. Please visit **HealthCare.gov** or call **800-318-2596** for more information and to obtain contact information for a Health Insurance Marketplace in your state.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's some of the employer information you will be asked to provide when you visit HealthCare.gov:

- As your employer, we offer an employer-sponsored health plan to full-time employees working at least 30 hours per week.
- The coverage under Louisburg health plan meets the minimum value standard and is considered "affordable" under the Affordable Care Act.

Employer Name: **Louisburg USD 416**	Employer ID Number (EIN) **48-0721788**	Employer Phone Number: **(913) 837-1700**
Employer Street Address: **29020 Mission Belleview Road**	City, State: **Louisburg, KS**	Zip: **66053**
Who May be contacted about employer health coverage at this job? **Lisa Kasper**		Email Address: **kasperl@usd416.org**

For more information about the Health Insurance Marketplace in your state, visit **HealthCare.gov** or call **800-318-2596**.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

IOWA – Medicaid
Website:
http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
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: http://www.indianamedicaid.com
Phone 1-800-403-0864

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

Legal Notices

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

This information is intended to be shared by employees with their spouse and dependents.

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Louisburg USD 416, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

This information is intended to be shared by employees with their spouse and dependents.

Continuation Coverage Rights Under COBRA

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), YOU must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide notice to Taben Group at the address noted on the following page.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1) **Disability extension of 18-month period of continuation coverage**
   If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. A copy of the Social Security Disability Award letter must be provided to Taben Group.

2) **Second qualifying event extension of 18-month period of continuation coverage**
   If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must notify Taben Group within 60 days of the second qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions:
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes
To protect your family's rights, let Louisburg USD 416 and the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Plan Administrator is:
Taben Group
Re: Louisburg USD 416
10875 Benson, Suite 130
Overland Park, KS 66210
Phone: (800) 675-7341
Email: tabencustomerservice@taben.com

Notes

Notes

Louisburg USD 416
2019-20 Employee Benefits Guide