**Shawnee Mission School District – Benefits Plan Year 2024 (Jan. 1 – Dec. 31, 2024)**
**Benefits Election and Salary Reduction Agreement**
**Section 125 Cafeteria Plan**

| | | | |
|---|---|---|---|
| **Employee ID #** | **Effective Date** | **Date of Hire** | **FTE** |
| ***Location*** | ***Pay Group*** | ***Job Code*** | |
| **Employee's Last Name** | **Employee's First Name** | | |
| **Address** | | **Date of Birth** | |
| **City** | **State** | **Zip** | |

For each desired benefit, place the option code (in parentheses) in the space provided at the bottom of the form. Benefits and monthly costs are subject to change based on contract negotiations and final approval by the SMSD Board of Education.

*Rates listed do NOT include the Wellbeing Incentive – which is an option for you to complete after coverage becomes effective.*

| **Blue Cross Blue Shield of KC – Medical** | | **Option Code** | **Monthly NPR Cost** |
|---|---|---|---|
| Preferred Care Blue – Blue Saver – | Employee Only | #1 | $0.00 |
| (QHDHP – High Deductible) | Employee plus Spouse | #2 | $596.08 |
| | Employee plus Child(ren) | #3 | $468.67 |
| | Employee plus Family | #4 | $1,217.19 |
| Blue Select Plus QHDHP | Employee Only | #11 | $0.00 |
| (QHDHP – High Deductible) | Employee plus Spouse | #12 | $456.58 |
| | Employee Plus Child(ren) | #13 | $342.85 |
| | Employee plus Family | #14 | $1,015.87 |
| Preferred Care Blue PPO | Employee Only | #21 | $131.08 |
| | Employee plus Spouse | #22 | $1,116.93 |
| | Employee Plus Child(ren) | #23 | $938.46 |
| | Employee plus Family | #24 | $1,968.85 |
| Blue Select Plus PPO | Employee Only | #31 | $50.00 |
| | Employee plus Spouse | #32 | $914.93 |
| | Employee Plus Child(ren) | #33 | $756.26 |
| | Employee plus Family | #34 | $1,677.32 |
| Blue Select Plus EPO | Employee Only | #41 | $50.00 |
| | Employee plus Spouse | #42 | $938.19 |
| | Employee Plus Child(ren) | #43 | $777.24 |
| | Employee plus Family | #44 | $1,710.90 |
| Blue Care HMO | Employee Only | #51 | $143.63 |
| | Employee plus Spouse | #52 | $1,143.38 |
| | Employee Plus Child(ren) | #53 | $962.31 |
| | Employee plus Family | #54 | $2,007.01 |

***If you are WAIVING Coverage – please write in WAIVE as your Option CODE***

**I am enrolling in the following plan: Option Code: _____ Cost Per Month: _____**

## Complete if you are enrolling in a High Deductible Plan

To be eligible for a High Deductible Plan and receive a District contribution for Employee Only Plans.

___ I certify that I am NOT covered under any other Health Insurance that is not a qualified HDHP Plan
___ I certify that I am NOT enrolled in Medicare or Medicaid
___ I certify that I have not received any Veteran's Administrative medical benefits in the last three months
___ I certify that I CANNOT be claimed as a dependent on someone else's tax return
___ I certify that neither my spouse nor I are enrolled in a "traditional" Medical Reimbursement (FSA)

Check only if you are NOT eligible

___ I understand and acknowledge that I am NOT eligible to open a Health Savings Account.

I understand and acknowledge that I am enrolling in the SMSD Blue Saver/Blue Select Plus High Deductible Health Plan (QHDHP) and that I have received the information about an H.S.A. If I have answered any question above incorrectly, there could be a tax implication or penalties if an H.S.A (Health Savings Account) is opened for an ineligible individual

I acknowledge that the H.S.A that I have applied for will be governed by the terms and conditions, including the fees, disclosed in the documents that will be mailed to me within (10) days after my H.S.A. has been opened. I request that UMB mail me a H.S.A. debit card so that I can use it to access funds in my H.S.A., and acknowledge that my use of the debit card will be governed by the Cardholder Agreement that will be sent with the card.

If electing the BlueSaver/Blue Select Plus Plan, I acknowledge that this High Deductible Health Plan ("QHDHP") is for use with a Health Savings Account. ("HSA")

I have a current Health Saving Account with UMB: Please circle YES or NO

Signature:_____Date: _____

**Please list the names of your dependents if you are enrolling them in your Medical Plan:**

| Name (s) of Insured - Medical | Date of Birth | Social Security Number | Gender |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Blue Care HMO – if you are enrolling in the Blue Care HMO – please include your PCP (Primary Care Physician)**
**Employee PCP# Name and or Number: _____**
**Dependent PCP# Name and or Number:_____**
**Spouse PCP# Name and or Number _____**

**WIR – Wellness Incentive Rate**

Participation in the ***Wellness Incentive Program*** provides an incentive of ***$50 per month***
Total Board contribution is ***$816.00 per month*** toward medical premium or monthly HSA contribution

The $50 monthly Wellness Incentive will be placed in the employee's HSA for those enrolled on the BlueSaver HDHP or the Blue Select Plus QHDHP
******No Wellness Incentive will be provided if the employee is ineligible to open the HSA******

**NPR = Non-Participation Rate**

Total Board contribution is ***$766.00 per month*** toward medical premium or monthly HSA contribution

| **Delta Dental of Kansas** | **Plan** | **Option Code** | **Monthly Cost** |
|---|---|---|---|
| Dental – PPO 2604-01 | Employee Only | #1 | $30.34 |
| | Employee Plus ONE | #3 | $61.52 |
| | Employee plus Family | #5 | $104.12 |
| Dental – Premier 2605-01 | Employee Only | #11 | $36.79 |
| | Employee Plus ONE | #13 | $78.06 |
| | Employee plus Family | #15 | $119.27 |

***IF you are waiving coverage, please write WAIVE as your OPTION CODE.***

**I am enrolling in the following plan: Option Code:_____ Cost Per Month:_____**

**Please list the name of the dependents you are enrolling in your Dental Plan.**

| Name(s) of Dependents Insured - Dental | Date of Birth | Gender |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| **Vision Service Plan** | **Plan** | **Option Code** | **Monthly Cost** |
|---|---|---|---|
| Vision | Employee Only | #1 | $14.99 |
| | Employee plus ONE/Family | #3 | $32.30 |

***IF you are waiving coverage, please write WAIVE as your OPTION CODE.***

**I am enrolling in the following plan: Option Code:_____ Cost Per Month:_____**

| Name(s) of Dependents Insured - Medical | Date of Birth | Gender |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Flexible Spending Account**

**Flex Made Easy** (Annual Maximum FSA Medical Contribution = $3,050.00)

FSA – Medical Annual Pledge $_____.____ _____**Waive**

Divide your Annual Pledge by the number of months in this current year that you will have coverage = Monthly Pledge $_____._____

**Flex Made Easy** (Annual Maximum FSA Dependent Care Contribution = $5,000.00 per household)

FSA – Dependent Care Annual Pledge $_____.____ _____**Waive**

Divide your Annual Pledge by the number of months in this current year that you will have coverage = Monthly Pledge $ _____._____

To complete your Flexible Spending Account enrollment – you must complete the attached form for FLEX Made Easy. You will **NOT** be enrolled in this program if you have not completed the enrollment form and returned to the Benefits Office

**All Benefits below are after-tax elections.**

**Sun Life – Short Term Disability**

To figure your cost per month

$_____.____ Annual Salary X **.70** = _____ X **.040** _____

Divide your total from the last line by 52 = _____

❑ **Accept** ❑ **Refuse**

***MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT I:***

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize that any required deductions from my earnings. (4) represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that the short term disability plan/long term disability plan includes limitations, exclusions and pre-existing conditions provision that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of fraud, as determined by a court of law.**

**Employee Signature:**_____ **Date:**_____

**Benefits Election and Salary Reduction Agreement, Section 125 Cafeteria Plan**

**Standard – Life Insurance** ***IF you are WAIVING Coverage – write WAIVE as your Cost per Month***

Employee Life with AD&D - Guaranteed Issue for Employees is $250k without requiring a Medical History Statement

Employee Coverage **Amount $_____ Cost per month$_____**

Spousal Life – Guaranteed Issue for Spouse is $25K without requiring a Medical History Statement

**Amount $_____ Cost per month$_____**

Child Life – 5K at $.75 per month or 10K at $1.50 per month

**Amount $_____Cost Per month:_____x #of Children_____**

***Employee is automatically the Beneficiary for Spousal Life and Child Life – you can only enroll in these coverages if you enroll in Employee Life***

***This rate could will change mid-year if you or your spouse reach the next age bracket due to a birth date.*** **Please complete the attached Enrollment form to complete your Life Insurance Enrollment and to select your beneficiaries.**

Standard Insurance Company **Enrollment and Change**

**To Be Completed By Benefits Office**

| Group Number | Date of Employment |
|---|---|
| 155117 | |

**To Be Completed By Applicant** ☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change ☐ Add or ☐ Delete Dependent Date of add/delete _____

| Your Name (Last, First, Middle) | Your Social Security Number | Birth Date | ☐ Male ☐ Female | |
|---|---|---|---|---|
| Your Address | | City | State | ZIP |
| Former Name (Last, First, Middle) *Complete only if name change* | | | Phone Number | |
| Employer Name<br>Shawnee Mission School District | | | Job Title/Occupation | |
| Hours Worked Per Week | Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year | | | |

**Coverage** *Check with your Benefits Office about coverage options available to you and Evidence Of Insurability requirements.*

**Life Insurance**

☐ Voluntary Life with AD&D Current Life amount $_____ Requested Life amount $_____

**Dependents Life Insurance**

☐ Spouse Life Current Life amount $_____ Requested Life amount $_____

Spouse Name_____ Date of Birth_____

☐ Child(ren) Life Current Life amount $_____ Requested Life amount $_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

**Beneficiary** *This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

| Primary - Full Name & DOB | Address | Soc. Sec. No. | Relationship | % of Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Contingent - Full Name & DOB | Address | Soc. Sec. No. | Relationship | % of Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Signature** I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

## Notices

**NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT:**

**Along with benefits detailed in your Certificate of Coverage and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.**

**SUMMARY OF BENEFITS AND COVERAGE NOTICE:**

**If you would like a copy of the Summary of Benefits and Coverage (SBC) for the product you are applying for, please see your employer for a copy. The SBC is available free of charge. SBCs are also available electronically at BlueKC.com. The information in the SBC is subject to change prior to your effective date.**

**NOTICE RELATING TO THE PROTECTION OF RELIGIOUS BELIEFS AND MORAL CONVICTIONS:**

**Your health plan's coverage does not include an elective pregnancy termination benefit.**

## On the day the coverage begins, will you or any of your dependents applying for this coverage be covered by other health or dental insurance or Medicare, including continuation of coverage?

**□ YES □ NO**

***(If yes please fill out Coordination of Coverage form.)***

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. d/b/a Blue Care Inc. (collectively, "Blue KC") as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions. I understand coverage under the Contract will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract. I represent that the statements and answers in this application are true, complete and correctly recorded. I understand that the statements and answers provided by me in this application shall be a basis of any coverage issued and the coverage is conditioned upon its truth.

I understand that if at any time it is determined by Blue KC that a person listed on this application did not meet the Contract's or Policy's definition of a dependent, Blue KC has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. Furthermore, I understand that if I intentionally misrepresented any of the information on the application, Blue KC has the right to terminate or rescind coverage for that person or for all persons under the application; however no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application. After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by Blue KC in accordance with applicable federal and state laws.

I authorize Blue KC as the insurer of my HDHP, UMB, and my Employer and/or their third party service providers, to exchange information about my identity, enrollment elections and status and other information necessary to establish my HSA at UMB, to facilitate direct deposits to my HSA, and to accomplish other purposes related to payment for my healthcare expenses. I agree to indemnify and hold harmless my Employer, UMB, Blue KC, and their third party service providers against all claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.

I have completed this benefit election form by marking the benefits in which I wish to participate. I understand that I must enroll annually for the Medical and Dependent Care Flexible Spending Accounts. I authorize the payroll office to withhold from my compensation, the dollar amount required for my contribution to the plan. The Board approved paid benefit amount will be treated as a district contribution to medical coverage only. I have read and agree to the terms and conditions of participation and understand that I may not revoke or change this agreement during the plan year unless I experience a change in my family status.

**Employee's Signature**_____ **Date**_____