2024-2025 BENEFITS AT A GLANCE

USD 475

GEARY COUNTY SCHOOLS

Jodie Cook, Coordinator of Benefits (785) 717 4016 • jodiecook@usd475.org

All benefits and rates represented in this file are applicable only to the benefit period stated above. Benefits and rates are subject to change each benefit period. Please refer to your employer's benefits department for verification.

Please note this brochure features *plan highlights only*. It is not a contract of insurance. The benefits are determined by the terms and conditions of the policy and certificates alone. Underwriting information and policy numbers are provided for each product. Please refer to your plan certificate(s), policies, and brochures for more detailed information. If a difference exists between this summary and the policy, the policy governs.

You may obtain a detailed brochure for each product at enrollment or by visiting https://secure.benebridge.com/assn/usd475.

ENROLLMENT DATES & TIMES

Effective Dates for Benefits

Health Insurance:
7/1/24
All Other Benefits:
6/1/24

Self Enrollment

Do not want to tackle it on your own, or have questions you want answered? Sign up for a One on One zoom enrollment slot and a licensed enroller from Pathway Financial Solutions will walk you through from start to finish.

Dates and Times:

April 29 May 10

8am 5pm

Sign Up Here!

Blue Cross - Blue Shield

As a homegrown company, established in Kansas in 1942, BCBS of Kansas has been historically sensitive to the desires of Kansans. Their daily mission is to provide their members the highest level of service available. Blue Cross and Blue Shield of Kansas is especially proud to report that in their 103-county Kansas service area, 98 percent of physicians and general acute care hospitals, and 94 percent of other providers gladly accept a Blue Cross card. What's more, through BlueCard®, members have access to more than 90 percent of all doctors and 80 percent of hospitals in the U.S., as well as providers in more than 200 countries and territories worldwide. In addition to a large network, members have the freedom of seeing a specialist without needing a referral from their PCP and several resources available to them for a healthier lifestyle.

Heritage Companies

Pathway Financial Solutions along with OFG Financial Services, Inc., have partnered together with Heritage Companies to provide health insurance options. For more than thirty years, Heritage Companies has been helping individuals and businesses with their insurance needs. Their commitment to establish trust and long lasting relationships with their clients has led to a team that continues to advance and excel in the areas of service, standards and technology. With many years of experience, Scott Lepley, Executive Partner, pledges to uphold the highest standards as a professional insurance agent and advisor. It is his desire for Heritage to be your single point of contact for health insurance questions, claims issues, etc.

Scott Lepley
7926 E 171st Street
Belton, Missouri 64012
(800) 686-7260
(816) 322-6350
www.heritagekc.com

Availability of Summary Health Information

Summary of Benefits and Coverage (SBC) for each deductible option are available to you. You may request the SBC at anytime, free of charge, upon request. Requests should be directed to:

Personnel Services
123 N Eisenhower
Junction City, KS 66441
(785) 717-4016
jodiecook@usd475.org

Health Insurance Options (Effective July 1, 2024–June 30, 2025)

	PPO Medi-Bridge Option 1	PPO Medi-Bridge Option 2	HDHP Medi-Bridge Option
Annual deductible	**In-network**	**In-network**	**In-network**
~ Individual	$6,000	$6,000	$6,000
~ Family	$12,000	$12,000	$12,000
Coinsurance (member portion)	$0	$0	$0
Total Deductible plus Coinsurance	$6,000/$12,000 individual/ two-or-more persons	$6,000/$12,000 individual/ two-or-more persons	$6,000/$12,000 individual/ two-or-more persons
Maximum out-of-Pocket (includes co-pays, deductible and coinsurance where applicable)	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700
Home & Office Visits	$35 Primary Care office visit copay/ $70 Specialist office visit copay	$35 Primary Care office visit copay/ $70 Specialist office visit copay	Subject to deductible
Qualified Preventive Benefit	Paid at 100%	Paid at 100%	Paid at 100%
Outpatient Labs, Radiology, and Advanced Imaging	Subject to deductible	Subject to deductible	Subject to deductible
Inpatient Hospital	Deductible	Deductible	Deductible
Outpatient Hospital	Deductible	Deductible	Deductible
Emergency Room	Deductible	Deductible	Deductible
Prescription Benefits	BlueRx Card $15/$50/$75/$150/20% up to $250 with Mail order is 2 1/2 x copay with ResultsRx formulary. A 90-day supply is available through the Extended Supply Network. The quantity per prescription is a 30-day pharmacy supply or 90- day mail order supply. Designated Specialty Pharmacy.		Deductible will apply first before copays
Deductible with Medi-Bridge GAP	$1,000 per person*	$2,000 per person*	$3,000 per person*
*	2 Family members must meet the per person deductible to reach the family cap.		
Medi-Bridge GAP Plan Benefit	$5,000	$4,000	$3,000

	PPO Gap $1000 Deductible	PPO GAP $2000 Deductible	HDHP $3000 GAP Deductible	BOE Contribution
Employee Only	Employee Cost	Employee Cost	Employee Cost	BOE Contribution
All Full Time	$197.89	$166.75	$111.27	$440
Employee +1	Employee Cost	Employee Cost	Employee Cost	BOE Contribution
All Full Time	$580.34	$514.38	$391.00	$530
Two Full Time EEs	$230.34	$164.38	$41.00	$880
Family	Employee Cost	Employee Cost	Employee Cost	BOE Contribution
All Full Time	$920.48	$825.86	$628.51	$825
Two Full Time EEs	$480.48	$385.86	$188.51	$1,265

Health Deductible Year runs July 1–June 30

This is a sample of the health insurance. For full description, see the policy.

Provider Network

Blue Choice Preferred-Care Blue Network is the name of the provider network. Using network providers save you and the plan money!

1. Visit https://www.bcbsks.com/find-a-doctor
2. Click on Find a Doctor/Hospital
3. Sign into BlueAccess® OR Choose Blue Choice Preferred-Care Blue Network if not signed in.

Let your mobile device be your guide for Blue Cross and Blue Shield of Kansas health care provider information. With the Blue National Doctor and Hospital Finder app you'll be able to quickly find an urgent care center or locate a contracting Blue Cross and Blue Shield provider. This app allows you to perform a nationwide search for a health care provider by specialty and name, either as a member or guest.

BlueAccess Registration

For access to valuable tools and resources to enhance your membership with BCBSKS, you will want to establish a BlueAccess® account. Follow the steps below to get your account your set-up.

1. Go to bcbsks.com/blueaccess. If you are the cardholder, select "Signup for BlueAccess."
2. On the "Getting Started" page , read the use agreement > check "I Agree" > select continue.
3. Create your profile. Provide the information requested in steps 1–4. Make sure you have your ID card handy.
4. Finish your registration. Feel free to explore the different links in BlueAccess, including HealthyOptions.

- Find a Blue Choice network provider
- Print your ID Card
- Review your claims
- Access discounts and coupons
- Take health risk assessment
- Set goals and monitor your progress
- Get assistance on a diet and exercise plan customized for you, and more...

Prescription Drug Information

Prescription Drug Look-Up

The medical plans offered by Geary County Schools, utilizes the BCBSKS ResultsRx Formulary list. You should review the Results Rx Formulary list to determine if a prescribed drug is covered under the Medical/Rx plan you are enrolled in.

1. Go to www.bcbsks.com
2. Scroll over Prescription Drugs
3. Click Find Drugs (Formulary)
4. Click on BCBSKS ResultsRx Medication List
5. Enter your medicine or condition name or download the ResultsRx Medication List
6. On this page you can also find other prescription drug information including the most up-to-date list of excluded drugs, quantity limits lists and non-formulary drugs that require prior authorization.

Mandatory Generics

Generic medications are mandatory unless the prescription practitioner has provided the override to receive the brand name drug.

Prescription Mail Order Program

The Mail Order program is through Express Scripts and offers home delivery with the highest standards of quality, safety and service for your prescription drug needs. Call **(833) 599-0511** or visit https://www.express-scripts.com/BCBSKS to learn more.

Prime Specialty Pharmacy Program

BCBSKS requires the Prime Specialty Pharmacy Program which benefits members with conditions requiring specialty medications: Accredo is the specialty pharmacy. Call **833-721-1620** or visit https://accredo.com/BCBSKS if you have questions.

Copay Maximization Program

Applicable to members covered under Medical Plan Option 1 or 2–Utilizers of some specialty medications may be required to take action to opt in (or opt out) of the Copay Maximization Program. This program allows the full-value of certain manufacturer coupons to be applied to the cost of the specialty drug, making the cost for the specialty drug $0 to the member.

BCBSKS Resources

HEALTHYOptions™

Disease Management

Learn how to manage your asthma, COPD, diabetes, heart disease, high blood pressure and high cholesterol.

Behavioral Health

Help for anxiety, depression and other behavioral health issues is just a few clicks away with free online or phone behavioral health screening.

Case Management

Obtain assistance with coordination of services and benefits for your complex medical conditions.

Wellness Management

BCBSKS registered nurses will provide you with the tools you need to manage stress, become tobacco-free or lose weight.

STRIVE Well Being with BCBSKS

Well-being is personal and it means something different to everyone. We all have our own interests, our own health goals and routines that make us unique. With Strive, powered by WebMD ONE, you get an experience that is unique to you – it's a more personalized well-being experience. Strive helps you take charge of your well-being by matching your unique personal needs and interests with the WebMD tools and resources that are right for you.

- By taking the Health Assessment, your results will give you a snapshot of your current health and any potential health risks. A personalized action plan will be developed with recommendations and a road to wellness guide that is unique to you.
- Daily Habits is a well-being solution that focuses on creating small, sustainable steps that lead to long-term, healthy lifestyle changes. Become happier, healthier and more engaged with Daily Habits.

Access Strive through your member BlueAccess account.

Seeking Care

To get the right care when you need it, it's important to understand your options. You can save time and money by going to an urgent care center instead of the ER if you need care right away. The medical plan has different costs for services. **Remember, if you are seeking treatment with a new provider, you should always check that they are an in-network provider through your medical insurance carrier. The medical network is Blue Choice Preferred-Care Blue.**

Preventive Care

To be your healthiest you, it is important that you regularly see your doctor and discuss preventive care to help you avoid serious illnesses or diseases. Routine checkups and screenings can help you avoid serious health problems by working with your doctor to help you reach your personal health and wellness goals.

What is preventive care?

Preventive care includes immunizations, screenings, counseling and education to help prevent or minimize the effects of serious health conditions at no extra cost to you. The appropriate preventive care services can vary for each person based on age, gender and other risk factors, including family medical history.

How do I know if preventive care is covered under my plan?

The Patient Protection and Affordable Care Act (ACA) requires non-grandfathered plans to cover certain preventive services at 100%. Covered preventive services are subject to change. You can visit the BCBSKS website at (bcbsks.com) to get the latest information. For more information on health care reform and preventive services,

You may want to visit...	To take care of....
Your doctor's office	Routine checkups, including Preventive Care services, immunizations, managing your general
Telehealth through AmWell	Minor health conditions such as sinus infections, urinary tract infections, respiratory condi-
An urgent care provider	Sprains, minor infections, minor broken bones (like a finger), or minor burns
A hospital emergency room	Life-threatening conditions, major broken bones, difficulty breathing, chest pain, severe inju-

BCBSKS Telehealth Services

Telehealth is a fast, convenient way to see a doctor virtually or connect via a phone call. If you are covered through Blue Cross Blue Shield of Kansas coverage you can have a live visit on your computer or mobile device with a doctor at a time that works for you. You can also call for service if you do not have a smart-phone or tablet device. Blue Cross provides telehealth services through American Well® (Amwell). With Amwell, employees register and the cost per visit is less than an emergency room or urgent care. It's easy-to-use, affordable, private and secure.

amwell®

Visit: bcbsks.com/telehealth Email: support@amwell.com

Call: (844) 733-3627

Why Use Amwell?

Choose Your Own Physician: You select a physician for your visit from a list of U.S. board-certified doctor and therapist profiles. All profiles include physician certifications, licenses and online patient ratings

- Available nationwide, 24/7/365
- Convenient Prescriptions: If a medication is prescribed, 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 accessed by the patient

How Much Does Amwell Cost?

The out-of-pocket cost of an Amwell doctor visit is $35 or $70 if enrolled in Option 1 or Option 2 of the medical plan (depending on the type of doctor you consult with for your particular situation and at least $49 if enrolled in the High Deductible Health Plan (Option 3). Other covered services include consultation visits with a dietician, social worker, behavioral health professional and psychiatrist at their respective costs.

How to Use Amwell

You can easily register for a telehealth visit and connect with a board-certified doctor in your area.

1. Download the Amwell app on any mobile device.

Download on the App Store GET IT ON Google Play

2. On a computer? Visit bcbsks.com/telehealth to get started.

3. Don't have a smart phone or tablet? Call (844) SEE-DOCS

When to Use Amwell

As an innovative patient consultation service, telehealth lets you interact with a doctor at your convenience for common conditions such as:

- Cold
- Flu
- Fever
- Rash
- Stomach Pain
- Sinus Infection
- Pink Eye
- Ear Infection
- Migraine

Also offering behavioral health and counseling services, known as teletherapy, Amwell's licensed therapists will provide treatment for several conditions, including:

- anxiety • attention deficit hyperactivity disorder (ADHD) • stress • bereavement • obsessive-compulsive disorder (OCD) • panic attacks • depression • trauma/post-traumatic stress disorder

Therapists will be available on demand or by appointment from 7 a.m. to 11 p.m. local time, 7 days a week.

Can My Family Use Amwell?

If your spouse and/or children are covered under your BCBSKS plan, they are eligible for telehealth services. A spouse should create their own Amwell account, but children or dependents under age 18 can be added to your account and have doctor visits on your behalf. You need to register first, and then your child or dependent can be added to the account. Children or dependents over the age of 18 must create their own Amwell account.

Medi-Bridge Gap Insurance

Underwritten by: PROSPERITY LIFE GROUP

BAY BRIDGE ADMINISTRATORS "Your solutions begin at the Bridge"

PATHWAY FINANCIAL SOLUTIONS

We've got you covered - inside and out

The Medi-Bridge Gap plan is structured to coordinate with your major medical plan to provide additional coverage for you and your dependents. This means there will be less up-front cash outlay and a reduced out-of-pocket balance to be paid by you. This plan is designed to help pay part of your $6,000 BCBS of KS PPO plan deductible and reduce your over all cost of coverage.

$1,000 Gap Deductible / $5,000 Gap Benefit

Includes coverage for confinement and services rendered as an inpatient in a hospital - room charges, surgery, in hospital physician charges, inpatient pharmacy and labs, and emergency room treatment after your copay is met. Also includes coverage for outpatient services including - hospital outpatient facility, outpatient surgical, diagnostics and other services that count towards your in-network plan deductible.

The Medi-Bridge Gap benefit is not for use with office copays, drug copays, ER or Urgent care copays or any other copay offered on your BCBS of KS health plan.

CLAIM EXAMPLE

$25,000 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$6,000	Total Out-of-Pocket Expenses
-	$5,000	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$1,000	Net Out-of-Pocket

CLAIM EXAMPLE

$3,500 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$3,500	Total Out-of-Pocket Expenses
-	$2,500	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$1,000	Net Out-of-Pocket

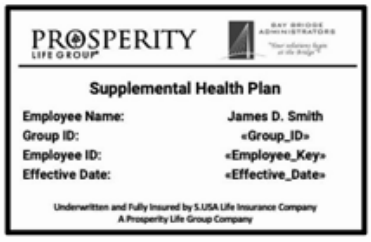
PROCESS FOR PROVIDING BENEFITS

Present your Medi-Bridge Gap and your BCBS ID cards at the time of service. You will need to provide BOTH cards.

NOT for Rx, primary care or specialist copays.

The claim is filed by your provider under the BCBS plan first. BCBS processes the claim and sends the provider an EOB (Explanation of Benefits). The provider will then file the claim for the Gap plan by submitting the itemized bill and BCBS EOB to Bay Bridge Admin.

The Gap benefit is not for use with plan copays.


PROSPERITY LIFE GROUP

Supplemental Health Plan

Employee Name: James D. Smith
Group ID: «Group_ID»
Employee ID: «Employee_Key»
Effective Date: «Effective_Date»

Underwritten and Fully Insured by S.USA Life Insurance Company
A Prosperity Life Group Company


Claims Submission Address:
Bay Bridge Administrators
P.O. Box 161690
Austin, TX 78716

For Claims & Customer Service Please Call:
1-800-845-7519

Payor ID: 89486

Underwritten and Fully Insured by S.USA Life Insurance Company
A Prosperity Life Group Company

Benefits are paid directly to your healthcare provider. ID cards are mailed in a large 8" x 11" plain white envelope.

Medi-Bridge Gap Insurance

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$2,000 Gap Deductible / $4,000 Gap Benefit

Includes coverage for confinement and services rendered as an inpatient in a hospital - room charges, surgery, in hospital physician charges, inpatient pharmacy and labs, and emergency room treatment after your copay is met. Also includes coverage for outpatient services including - hospital outpatient facility, outpatient surgical, diagnostics and other services that count towards your in-network plan deductible.

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CLAIM EXAMPLE

$25,000 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$6,000	Total Out-of-Pocket Expenses
-	$4,000	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$2,000	Net Out-of-Pocket

CLAIM EXAMPLE

$3,500 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$3,500	Total Out-of-Pocket Expenses
-	$1,500	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$2,000	Net Out-of-Pocket

PROCESS FOR PROVIDING BENEFITS

Present your Medi-Bridge Gap and your BCBS ID cards at the time of service. You will need to provide BOTH cards.

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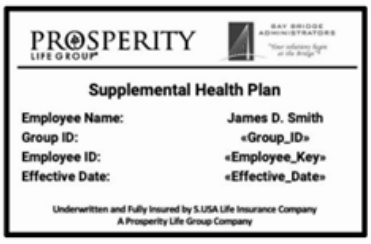
The claim is filed by your provider under the BCBS plan first. BCBS processes the claim and sends the provider an EOB (Explanation of Benefits). The provider will then file the claim for the Gap plan by submitting the itemized bill and BCBS EOB to Bay Bridge Admin.

The Gap benefit is not for use with plan copays.


PROSPERITY LIFE GROUP

Supplemental Health Plan

Employee Name:	James D. Smith
Group ID:	«Group_ID»
Employee ID:	«Employee_Key»
Effective Date:	«Effective_Date»

Underwritten and Fully Insured by S.USA Life Insurance Company
A Prosperity Life Group Company


Claims Submission Address:
Bay Bridge Administrators
P.O. Box 161690
Austin, TX 78716

For Claims & Customer Service Please Call:
1-800-845-7519

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CLAIM EXAMPLE

$25,000 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$6,000	Total Out-of-Pocket Expenses
-	$3,000	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$3,000	Net Out-of-Pocket

CLAIM EXAMPLE

$3,500 Medical Bill

	$6,000	Major Medical Deductible
+	$0	Major Medical Coinsurance
Amount owed without a Medi-Bridge plan	$3,500	Total Out-of-Pocket Expenses
-	$500	Medi-Bridge GAP Benefit
Amount owed with a Medi-Bridge plan	$3,000	Net Out-of-Pocket

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PROSPERITY LIFE GROUP

Supplemental Health Plan

Employee Name:	James D. Smith
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Dental Coverage Information **(Effective June 1, 2024-May 31, 2025)**

With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to your overall well-being.

The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage (up to annual maximum benefit), with no deductible, for all services covered under the plan when an in-network dentist (Delta Dental Premier or Delta Dental PPO) is seen. If an out-of-network dentist is seen, the underlying contract applies including deductibles and coinsurance levels.

Unlimited Cleanings -The plan will allow for unlimited cleanings. This includes regular/prophylaxis cleanings and periodontal maintenance cleaning.

Coverage Level	Monthly Rates
Employee	$31.25
Employee + 1	$59.06
Family	$99.03

Dental Plan Benefits	
Diagnostic/preventive services Cleanings/fluoride	100%
Basic services Simple extractions/ fillings	50%
Major services Crowns/dentures/caps/bridge	50%
Annual Maximum Benefit	$1,500 per person, per plan year

Provider Network

1. Go to www.deltadentalks.com
2. Click on 'Member' across the top of the page
3. Click on 'Find a Dentist'
4. Choose the type of dentist under 'Specialty'
5. Choose your plan—click on 'Delta Dental Premier' or 'Delta Dental PPO'
6. Enter your search location zip code
7. Click on 'Find Dentist' If you have any questions about whether your dentist participates with Delta Dental, contact Customer Service toll-free at (800) 234-3375

Vision Coverage Information (Effective June 1, 2024-May 31, 2025)

EXAM	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Comprehensive eye-health vision examination includes refraction and dilation	100% after exam fee	$15	$50
FLEXIBLE EXAM OPTION: In the event that a member has an eye exam included with another plan, Vision Care Direct applies a credit to be used for other services or materials in lieu of a Vision Care Direct eye exam. An explanation will be provided to you by your provider at time of service in regards to the amount and how it was applied to your additional services or materials.			$0

SPECTACLE LENSES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 glass or plastic	100% after materials fee	$15	$50
Lined Bi-focal (FT28) in CR-39 glass or plastic	100% after materials fee	$15	$75
Lined Tri-focal (FT7x28) in CR-39 glass or plastic	100% after materials fee	$15	$100
Progressive (no-line multi-focal) in CR-39 glass or plastic	Up to retail price of lined tri-focal	$15 + Overage above allowance	$100
Upgrades and/or add-ons (anti-reflective coating, high-index, photochromic, etc.)	$0	Standard retail price	$0
POLYCARBONATE FOR KIDS (PK): Polycarbonate lenses for dependent children up to age 18	100% after PK fee	$25	$0

FRAMES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Frame allowance as indicated by desired plan toward standard retail price of any frame in the provider's office.	Up to $130	Overage above $130 allowance	$60

VCDPLUS LENS OPTION (IN LIEU OF SPECTACLE LENS OPTION ABOVE)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Bi-focal (FT28) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Tri-focal (FT7x28) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Progressive (up to a digital free form full back surface) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Upgrades and/or add-ons (high-index, photochromic, tint, etc.)	$0	Standard retail price	$0

CONTACT LENS (IN LIEU OF GLASSES)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
ELECTIVE: Equal to frame allowance of desired plan, in lieu of frames and spectacle lenses. Can be used toward multi-focal contacts and contact lens fitting fees.	Up to $130	Overage above $130 allowance	Up to $80
MEDICALLY NECESSARY: Requires prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular aphakia and/or binocular aphakia.	Up to $250	Overage above $250 allowance	Up to $80

Coverage Level	Exam Only	Materials Only	Exam + Materials
Employee	$4.40	$11.26	$15.46
Employee + 1	$6.96	$17.96	$24.68
Employee + Children	$8.06	$20.76	$28.50
Family	$13.46	$35.12	$48.20

This is a Summary of benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all the parties and supersedes all other written or oral communication.

Vision Coverage Information—Vision Care Direct

At last, you finally have the freedom to use your materials allowance the way you want without all the surprise out of pocket expenses. With VCD PLUS™, you'll have access to high definition (single vision, bifocal, trifocal or premium progressive) lenses, premium anti-reflection coating, scratch resistant coaching and UV protection all for one low price!

		STANDARD VCD	VCD PLUS
FRAME	Up to $130	✓	✓
LENSES	Single Vision, Bifocal, Trifocal	✓	✓
	Progressive		✓
EXTRAS	Non-Glare Coating		✓
	Scratch Resistance		✓
	Water Repellent		✓
	Oil Repellent		✓
PROVIDER NETWORK		Any provider listed on www.VisionCareDirect.com VISION CARE DIRECT	Any provider listed on www.VisionCareDirect.com with this logo: VCDPLUS

*Progressive lens allowance on the Standard VCD option is equal to doctor's retail cost of standard trifocal lens. Difference between retail cost of progressive and trifocal lens is patient responsibility.

** Lens enhancements not listed as included options above (polycarbonate, high-index, photochromic, etc.) can be added at doctor's usual and customary rate.

*** Contact lens allowance of $130 may be used in lieu of the frame/spectacle lens allowance options listed above. GENERAL LIMITATIONS AND EXCLUSIONS: This vision plan is designed for routine eye care and materials expense incurred while the membership is in force. Plan allowances cannot be combined with any other discounts, promotional offers or other advertised specials including, but not limited to, discounts, coupons, or two-for-one materials specials offered by the providers at their individual offices. Members must choose between using their Vision Care Direct allowances or the provider's special offers. Unused allowances do not roll over into next allowance period. We do not provide allowances for the following:

- Services and materials not included on Allowance Summary including cosmetic items and add-ons
- Experimental or non-conventional treatment or device
- Medical or surgical treatment of the eyes
- Orthopedics or vision training and any associated supplemental testing
- Any injury or illness covered by Workers Compensation or similar law
- Subnormal vision aids, non-prescription or aniseikonia lenses
- Contact lenses for cosmetic enhancement such as changing eye color except as included in the Allowance Summary
- Two pairs of glasses in lieu of bifocals, trifocals, or progressives
- Care for services or materials received while traveling in a foreign country without a detailed receipt in English
- Oversized 61 and above lens or lenses
- Additional charge may apply for Rx above +/- 6 sphere and/or 6 cylinder
- Charges incurred after membership ends

Group Term Life Insurance (Effective June 1, 2024-May 31, 2025)

Geary County USD 475 provides eligible employees the opportunity to purchase Voluntary Life Insurance on yourself, spouse, and dependent children. You pay the total cost of this benefit through convenient payroll deductions. This benefit is offered through Manhattan Life Insurance Company. Below is a brief summary of coverage options. Contact Human Resources to update your beneficiary information.

Employee Coverage

- $25,000 to 5x annual salary or $500,000, whichever is less
- Purchased in increments of $5,000
- Guarantee issue at initial opportunity is $200,000 (under age 60); or $25,000 (age 60-64)
- Your coverage amount reduces to 50% at age 70
- Accelerated death benefit available if diagnosed with a terminal condition

Spouse Coverage

- $10,000 to $100,000, not to exceed 50% of employee election
- Purchased in increments of $5,000
- Guarantee issue at initial opportunity is $25,000
- Coverage terminates at age 70

Child Coverage

- 10 days to 6 months old: $1,000
- 6 months to age 19 (25 if full-time students): $10,000 or $20,000

Spouse and Dependent Child(ren) coverage can only be taken in conjunction with Employee coverage. Dependent coverage may not be taken on stand-alone basis. A spouse or child who is insured as an employee under this plan cannot also be insured as a dependent. If both you and your spouse are insured under this plan as employees, only

Guarantee Issue

Guarantee issue is the opportunity to purchase life insurance with no medical questions asked. Guarantee issue is offered at your initial opportunity only. If you enroll in the plan as a new hire, you will not have to provide medical evidence of insurability to qualify for coverage up to the Guarantee Issue Amount. You may need to provide evidence for amounts over the Guarantee Issue Amount. If you **do not** enroll as a new hire, and you decide you'd like coverage or increased coverage at a later time, you may be required to provide evidence of insurability. Your future opportunities to enroll in the plan may be limited, and you may be denied coverage for certain amounts.

Annual Enrollment Option–Employee Coverage Only

- If you are actively at work, are less than age 60 and are not currently enrolled in this plan you may elect $25,000 without evidence of Insurability. Evidence of Insurability is required for amounts that exceed $25,000.
- If you are actively at work, are less than age 60 and insured under this plan for at least 6 months you may enroll for an additional $25,000 each annual re-enrollment period without Evidence of Insurability. Additional amounts that exceed $25,000 will require Evidence of Insurability. The additional $25,000 available during the annual re-enrollment is limited to accumulative total of $100,000 of additional coverage or up to the Guarantee Issue Amount, whichever is less. Evidence of Insurability will be required for amounts that exceed the Guarantee Issue Amount. In no event will your benefit amount exceed the $500,000 plan maximum or be greater than 5 times your annual earnings.

Your voluntary life insurance ends if: 1. your employment ends; 2. you are no longer Actively-At-Work; 3. premiums are not paid; 4. you are no longer an eligible employee; 5. Voluntary Life Insurance is no longer being provided by the Participating Employer; 6. the policy terminates; 7. you enter the military, naval or air force of any country or international organization on a full-time or active duty basis; 8. active-duty military spouses cannot be covered under optional life insurance or 9. the Participating Employer's coverage under the policy ends.

Group Term Life Insurance

Employee Monthly Premium

Age	$25K	$75K	$125K	$175K	$225K	$275K	$325K	$375K	$425K	$475K	$500K
18 to 29	$0.93	$2.78	$4.63	$6.48	$8.33	$10.18	$12.03	$13.88	$15.73	$17.58	$18.50
30 to 34	$1.38	$4.13	$6.88	$9.63	$12.38	$15.13	$17.88	$20.63	$23.38	$26.13	$27.50
35 to 39	$1.60	$4.80	$8.00	$11.20	$14.40	$17.60	$20.80	$24.00	$27.20	$30.40	$32.00
40 to 44	$1.85	$5.55	$9.25	$12.95	$16.65	$20.35	$24.05	$27.75	$31.45	$35.15	$37.00
45 to 49	$4.48	$13.43	$22.38	$31.33	$40.28	$49.23	$58.18	$67.13	$76.08	$85.03	$89.50
50 to 54	$7.75	$23.25	$38.75	$54.25	$69.75	$85.25	$100.75	$116.25	$131.75	$147.25	$155.00
55 to 59	$15.00	$45.00	$75.00	$105.00	$135.00	$165.00	$195.00	$225.00	$255.00	$285.00	$300.00
60 to 64	$28.50	$85.50	$142.50	$199.50	$256.50	$313.50	$370.50	$427.50	$484.50	$541.50	$570.00
> 64	$42.75	$128.25	$213.75	$299.25	$384.75	$470.25	$555.75	$641.25	$726.75	$812.25	$855.00

Spouse Monthly Premium

Age	$10K	$20K	$30K	$40K	$50K	$60K	$70K	$80K	$90K	$100K
18 to 34	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
35 to 39	$1.79	$3.58	$5.37	$7.16	$8.95	$10.74	$12.53	$14.32	$16.11	$17.90
40 to 44	$2.82	$5.64	$8.46	$11.28	$14.10	$16.92	$19.74	$22.56	$25.38	$28.20
45 to 49	$4.35	$8.70	$13.05	$17.40	$21.75	$26.10	$30.45	$34.80	$39.15	$43.50
50 to 54	$6.91	$13.82	$20.73	$27.64	$34.55	$41.46	$48.37	$55.28	$62.19	$69.10
55 to 59	$10.24	$20.48	$30.72	$40.96	$51.20	$61.44	$71.68	$81.92	$92.16	$102.40
60 to 64	$19.80	$39.60	$59.40	$79.20	$99.00	$118.80	$138.60	$158.40	$178.20	$198.00
65 to 69	$19.80	$39.60	$59.40	$79.20	$99.00	$118.80	$138.60	$158.40	$178.20	$198.00

Child(ren) Monthly Premium

$10K	$20K
$2.00	$4.00

More Info:

secure.benebridge.com/brochures/common_ofg/rsl_term_life_100+.pdf

Disability Income Protection (Effective June 1, 2024-May 31, 2025)

In this time of insuring everything you own – your house, car, boat – many people completely disregard one of their most valuable assets: their income. The disability income protection is administered by Reliance Standard Life Insurance Company and allows you to insure a portion of your income should you become unable to work due to a disability.

Plan Features

- Receive 66 2/3% of your salary, not to exceed $9,000 monthly benefit
- Benefits are paid monthly after you have satisfied your elimination period, up to 26 weeks
- Benefits are coordinated with your employer paid "sick leave". If you are receiving "sick leave" benefits from your employer, the disability benefit will be reduced.

Medical Treatment Benefit

- $75, limited to one Doctor's visit per day, for a Sickness or Injury that requires treatment by a Doctor **other than in a Hospital Emergency Room**
- $250, limited to one Emergency Room visit per day, for a Sickness or Injury that requires treatment by a Doctor in a Hospital Emergency Room

To receive the Medical Treatment Benefit, the expense must be incurred on a regular scheduled work day, no part of which you spent Actively-at-work. This Benefit is limited to not more than four (4) occurrences per calendar year for any combination.

Hospital Confinement

If you are confined as an Inpatient due to Sickness or Injury, this plan pays a benefit of:

- $1,000 for the 1st day of Hospital Confinement
- $500 payable on the 2nd day and 3rd day of Hospital Confinement
- $150 payable on the 4th day to the 30th day of Hospital Confinement

This payment will begin on the 1st day of Confinement and continues up to a 30-day maximum benefit period under the following conditions:

1. The Confinement must be caused by Sickness or Injury; and
2. The Confinement must begin while the Insured is covered under the Policy

Professional Employees

You may elect an elimination period of 14 or 30 days for injury and sickness.

OPTION 1 Injury/Sickness - $0.77 per $100 Monthly Benefit

14 days or the end of the employee's accumulated sick leave, whichever is greater

OPTION 2 Injury/Sickness - $0.62 per $100 Monthly Benefit

30 days or the end of the employee's accumulated sick leave, whichever is greater

Classified Employees

Injury/Sickness - $0.77 per $100 Monthly Benefit (Board Paid)

14 days or the end of the employee's accumulated sick leave, whichever is greater

Pre-Existing Condition Limitations

Reliance Standard will not pay benefits for any period of disability caused or contributed by, or resulting from, a pre-existing condition. A "pre-existing condition" means any injury or sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within 12 months before your effective date of coverage. The pre-existing condition limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Additional Information

Certified Staff: https://secure.benebridge.com/brochures/ofg/usd475/rsl_dis_cert.pdf

Classified Staff: https://secure.benebridge.com/brochures/ofg/usd475/rsl_dis_class.pdf

Short Term Disability Insurance: this is not a contract of insurance. The terms and conditions of coverage are set forth in Policy Number G 647679, on Policy Form Number LRS 9384 0107. The Policy is subject to the laws of the state in which it is issued

Health Savings Accounts (Effective June 1, 2024-May 31, 2025)

What is a Health Savings Account?

A Health Savings Account (HSA) is a tax-advantaged savings account designed to help individuals with high-deductible health plans (HDHPs) save for medical expenses. The funds in an HSA can be used to pay for qualifying healthcare expenses such as deductibles, copayments, prescription drugs, and other eligible medical, dental, and vision expenses.

Who Qualifies for an HSA?

You must be enrolled in a qualified HDHP. HDHPs have higher deductibles and lower premiums compared to traditional health insurance plans. You must not be covered by any other health insurance plan that is not an HDHP. This includes coverage under a spouse's plan, unless it is also an HDHP.

Key Features of an HSA:

- **Eligibility:** To open an HSA, you must be enrolled in an HDHP and not be covered by any other non-HDHP insurance.
- **Contributions:** Contributions to an HSA can be made by the account holder, their employer, or both. Contributions are tax-deductible, and there are annual limits set by the IRS. Annual max for 2024 is $4,150 for an individual and $8.300 for a family.
- **Tax Benefits:** Contributions to an HSA are made with pre-tax dollars (or tax-deductible if made with post-tax dollars), earnings grow tax-free, and withdrawals for qualified medical expenses are also tax-free.
- **Portability:** The account is owned by the individual and remains with them even if they change jobs.
- **Rollover:** Any unused funds in an HSA roll over from year to year, allowing the account balance to accumulate over time.

USD 475's Health Savings Accounts are offered through **Central National Bank**. There is no fee associated with setting up an account and no minimum deposit required. All employees who wish to have HSA contributions payroll deducted **must** set one up with Central National.

Central National Bank
Money for Life

785-238-4114
802 N Washington St,
Junction City, KS 66441

To see what may or may not qualify as an HSA eligible expense, see the link below:
https://hsastore.com

Flexible Spending Accounts (Effective June 1, 2024-May 31, 2025)

Why should you choose to participate in 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 a few types of FSAs available to you at USD 475:

1) **Healthcare Flexible Spending Account (Limited Purposed is available for High Deductible Plans)**
   A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses. Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You may increase your spendable income by an average of 30% of your annual contribution with the tax savings. ($3,200 per plan year max, $640 rollover.)

2) **Dependent Care Flexible Spending Account**
   A dependent care account (DCA) is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work. ($5,000 per plan year max, no rollover.)

Increase Your Take Home Pay	With FSA	Without FSA
Annual Gross Pay	$30,000	$30,000
FSA Contributions	-$2,400	$0.00
Taxable Income	$27,600	$30,000
Deductions From Pay (Fed Inc Tax (assumes 30% tax bracket), FICA Tax, State Inc Tax)	-$8,280	-$9,000
Healthcare Expenses	$0.00	-$2,400
After-Tax Take Home Pay	$19,320	$18,600
Annual Tax Savings	$720	$0.00

LIMITED PURPOSE FSA

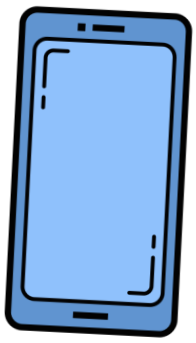
A limited-purpose FSA is a flexible spending account that allows you to set aside pre-tax dollars for dental and vision expenses for you and your dependents, even if they are not covered under your primary health plan. You are eligible to open a limited-purpose FSA if you are enrolled in a health savings account (HSA). You choose an annual election amount, up to $3,200. At the beginning of the plan year, your account is pre-funded and your full contribution is immediately available for use. Your election amount is then deducted from your paychecks in equal installments throughout the year.

Account Access as Mobile as You Are!

Have the account information you need, right when you need it most. The Bay Bridge Administrators mobile app makes it easy to manage your flexible spending accounts on the go. The secure mobile app gives you access to your FSA with the following features:

- Free application available for Apple or Android smart devices
- Gain instant access by entering the same username and password that you create on the WealthCare Portal
- View account balances and transaction history
- Attach receipts by taking a photo
- Add or edit text message alerts
- Contact the administrator for assistance

Download Bay Bridge Administrators from the Apple App Store or Android Marketplace today!



Medical Expense Reimbursement - https://secure.benebridge.com/brochures/common_ofg/med_reim.pdf
Limited Purpose - https://secure.benebridge.com/brochures/common_ofg/limited_purpose.pdf
Dependent Care - https://secure.benebridge.com/brochures/common_ofg/dep_care.pdf

REMINDER *Always request a DETAILED RECEIPT from the provider, even when using the FSA Debit Card. The IRS requires you keep them for your tax records, and you will also need them if your FSA vendor requests substantiation that an expense is a qualified FSA expenditure.*

Individual Cancer and Specified Disease Insurance

(Effective June 1, 2024-May 31, 2025)

When Cancer Strikes. . .

- Expenses increase. . . travel & lodging to and from treatment, medication, co-payments, special diets, and treatment not covered by health insurance, etc.
- Income decreases. . . missed work for both you and your spouse (will you be able to afford to have your spouse with you when you have to go to treatment?)

This plan pays you!

- Major medical pays the doctor and hospital
- This Plan pays money directly to you and you can use the money any way you want

Highlights

- Pays regardless of other coverage
- Covers certain transportation and lodging
- Wellness Benefits
- Donor Benefits
- In and out of hospital benefits
- Many benefits have no lifetime max
- Portable (take it with you)
- Renewable for life

Premiums for this policy are based on issue age on the effective date of the policy. You lock in your age class for the life of the policy. The premium for this policy and rider if selected may change but will not change because you attain the next premium rate age classification.

Individual Cancer - https://secure.benebridge.com/brochures/common_ofg/mhl_cancer.pdf -for details
https://secure.benebridge.com/brochures/common_ofg/mhl_cancer_rates.pdf–for rates

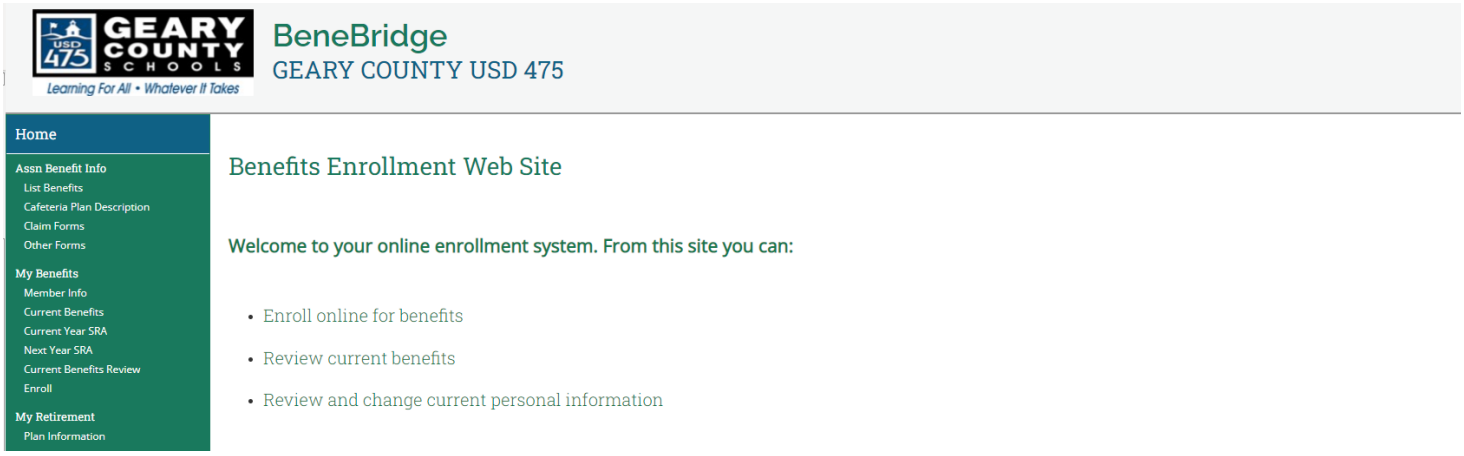
Cancer Insurance Monthly Premiums (BBAC–01)				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$7.49	$15.26	$32.35	$47.03
One Parent Family	$13.84	$21.60	$38.83	$52.60
Two Parent Family	$15.94	$30.94	$64.38	$93.15

Cancer Insurance Monthly Premiums (BBAC–352)				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$13.09	$24.96	$52.86	$79.11
One Parent Family	$23.97	$35.85	$63.97	$88.47
Two Parent Family	$27.67	$51.09	$105.94	$157.14

The previous information is for summary purposes only. If you would like to see a full brochure of the individual product, go to the following link & follow these instructions below.

Geary County USD 475 BeneBridge web page: https://secure.benebridge.com/assn/usd475

On the left side click "List Benefits" for the individual products full brochure.
If you would like to be able to log in to view what you are currently enrolled in, please follow the instructions in the self-enrollment guide.



Retirement Reality*

- *2 out of 3 retirees are unable to maintain standard of living in retirement*
- *56% of Americans have less than $10,000 saved for retirement*
- *$6.6 trillion retirement income gap for those between the ages of 32-64*
- *38.3 million working-age households (45%) have $0.00 retirement account assets*
- *50% of retirees retire earlier than planned*
- *75% expect to work in retirement; 25% actually can and do*
- *80% of working households have retirement savings less than 1x their annual income*

With the options of a 403(b) plan, you have the opportunity to begin the process of saving for your retirement future.

It's easy to do:

- Set up your account with one of the approved providers. They will assist in determining an investment strategy that best fits your investment objective risk tolerance & financial circumstance.
- Determine the amount of money you want to deduct from your check on a per-pay period basis. The money will be withheld from your check and invested into your established account .

It's really that easy! Contact one of the approved providers to get started!

** Sources: Center for Retirement Research, Pension Rights Center, National Institute on Retirement Security, Time.com, "The Retirement Reality Gap", Money Magazine April 15, 2014.*

403(b) Retirement Plan Highlights

Contributions

What kinds of contributions may be made to this plan?

- This plan provides for pre-tax salary reduction contributions, post-tax Roth salary reduction contributions, and rollovers. There are no employer contributions.
- Pre-tax contributions are deducted **before** you pay current income taxes. Pre-tax investments grow tax-deferred and the contributions and any earnings are taxed when you take a distribution from this plan.
- Post-tax Roth contributions are deducted **after** you pay current income taxes. Earnings on post-tax Roth contributions will never be taxed if you are 59 ½, die, or become disabled and have held the Roth account for 5 years at the time of its distribution from this plan.
- You may transfer benefits from a former employer's eligible retirement plan into this plan.

How much may I contribute?

- You can contribute up to 100% of your compensation to this plan up to the limit allowed under the Internal Revenue Code ($23,000 in 2024).
- If you are age 50 or older you can contribute a "catch-up" contribution of up to $7,500 (2024).

Can I ever lose my benefits?

- You are always 100% vested in your salary reduction contributions. This means the value of your contributions and earnings are yours when you terminate employment with your employer, without respect to your years of service.

What do I have to do to start contributing?

- Automatic payroll deduction withdraws your contributions directly from your paycheck after you complete a Salary Reduction Agreement and return it to your financial representative or your employer. You may commence making contributions or modify the amount of your current contributions at any time by modifying your Salary Reduction Agreement.

Investments

Where are my contributions invested?

- You may choose the 403(b) custodial account or annuity contract you want from the list of approved investment providers and 403(b) investment products located on the Bay Bridge website, http://sfr.baybridgeadministrators.com/sfr_select_employer.php?id=184

How are my contributions invested?

- You select how you want your contributions to be invested from among the investment options available under each approved investment provider's product.
- Your investment provider's custodial account or annuity contract will determine how often you may change your investment mix.

Employee Assistance Program

Life can be stressful. At some point, we all experience personal challenges either on the job or at home. Whether it's the loss of a loved one, a struggle with an addiction or relationship difficulties, it's important to be able to talk to a caring professional who can help you identify and resolve your concerns.

Left unresolved, these issues could adversely affect your work productivity and general well-being. USD 475 offers an Employee Assistance Program (EAP) administered through Pawnee Mental Health Services **at no cost to you or your immediate family members.** This program is a life-management resource designed to help you navigate your personal challenges.

EAP Assistance

You or your family member may call to request an appointment with one of our EAP consultants—a licensed clinical social worker, a licensed masters level psychologist or a licensed psychologist (Ph.D.). Confidentiality is assured. No one will be informed of your request for help.

You'll be asked to provide some background information about yourself and to describe the problem or situation that brought you in. Sometimes a resolution can be reached in one or two sessions. If not, the consultant will make a referral to services that meet your needs and your resources. You may be referred for therapy or the consultant may suggest a support group or financial counseling by another agency.

Each individual may make up to three assessment/referral visits per problem per year. If more help is needed, referrals are made with consideration for the employee's regular health insurance and/or other benefits and, when possible, to services which base fees on ability to pay.

The EAP assists employees and their family members with personal or job-related concerns such as:

- Stress
- Marital
- Divorce
- Family
- Drugs
- Alcohol
- Financial
- Emotional
- Psychological
- And more...

EAP Providers

Pawnee Mental Health

You may call one of the three locations below to request an appointment.

814 Caroline Avenue
Junction City, KS 66441
(785) 762-5250

210 W 21st Street
Concordia, KS 66901
(785) 243-8900

2001 Claflin Road
Manhattan, KS 66502
(785) 587-4300

For more information visit:

WWW.PAWNEE.ORG

Notes

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insuance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

Jodie Cook
123 N Eisenhower Dr
Junction City, KS 66441
(785) 717-4000
JodieCook@usd475.org

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

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: **USD 475 Geary County**
Employer EIN: **48-6019142**
Employer Address: **123 N Eisenhower**
Junction City, KS 66441
Employer Phone Number: **(785) 717-4000**

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

- As your employer, we offer a health plan to:
  - ☑ Some employees. Eligible employees are
    All full-time eligible employees working 30 or more hours per week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Legal spouse and dependents

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: 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.

NOTICE OF 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.
To request special enrollment or obtain more information, contact Jodie Cook at 123 N Eisenhower Dr, Junction City, KS 66441, (785) 717-4000, JodieCook@usd475.org
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NOTICE OF PRIVACY PRACTICES

USD 475 Geary County
123 N Eisenhower Dr
Junction City, KS 66441
(785) 717-4000

Privacy Official:
Jodie Cook
123 N Eisenhower Dr
Junction City, KS 66441
(785) 717-4000
JodieCook@usd475.org
Effective Date: 06/01/2020

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used

1 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.

- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Jodie Cook
  123 N Eisenhower Dr
  Junction City, KS 66441
  (785) 717-4000
  JodieCook@usd475.org
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICES

Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $5000 deductible (in-network) and 0% coinsurance (in-network) and $5000 deductible (out-of-network) and 20% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (785) 587-2000.

Annual Notice
Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (785) 587-2000 for more information.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the USD 475 Geary County Welfare Benefit Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (785) 717-4000.

EMPLOYER'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

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)**.

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

For information on programs outside of Kansas please refer to the compliance brochure located here: https://secure.benebridge.com/brochures/ofg/usd475/notice.pdf

MICHELLE'S LAW NOTICE

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the USD 475 Geary County group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of USD 475 Geary County group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the USD 475 group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the USD 475 Geary County group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The USD 475 Geary County group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary
- Student must be enrolled in the plan immediately prior to the first day of the medically necessary leave of absence.

To obtain additional information, please contact:

Jodie Cook
123 N Eisenhower Dr,
Junction City, KS 66441
(785) 717-4000
JodieCook@usd475.org

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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).

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from USD 475 Geary County 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 475 Geary County 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. USD 475 Geary County has determined that the prescription drug coverage offered by the USD 475 Geary County Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current USD 475 Geary County coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current USD 475 coverage, be aware that you and your dependents will 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 475 Geary County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information call Jodie Cook at (785) 717-4000. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through USD 475 Geary County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: USD 475 Geary County
Contact--Position/Office: Jodie Cook, Benefits Coordinator
Address: 123 N Eisenhower Dr, Junction City, KS 66441
Phone Number: (785) 717-4000

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURES

Genetic Information Nondiscrimination Act of 2008
The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GENERAL NOTICE OF COBRA RIGHTS

(For use by single-employer group health plans)
Continuation Coverage Rights Under COBRA

Introduction
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 it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (under 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 lose coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (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."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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 30 days after the qualifying event occurs. You must provide this notice to:

Jodie Cook
Benefits Coordinator
123 N Eisenhower Dr
Junction City, KS 66441
(785) 717-4000
jodiecook@usd475.org

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

Disability extension of 18-month period of COBRA 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.

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.

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, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 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.

Plan contact information
USD 475 Geary County Welfare Benefit Plan
Jodie Cook
123 N Eisenhower Dr
Junction City, KS 66441
(785) 717-4000
jodiecook@usd475.org

GENERAL FMLA NOTICE

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Requesting Leave
Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.
Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

USERRA NOTICE

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act
USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation
If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USADOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Refer to this list when you need to contact one of your benefit vendors.

For general information contact Personnel Services.

Employee Customer Service Contacts		
Company	Website	Phone Number
Blue Cross Blue Shield of Kansas	www.bcbsks.com	800-432-3990
Delta Dental of Kansas	www.deltadentalks.com	800-234-3375
Vision Care Direct	visioncaredirect.com	877-488-8900
BayBridge Administrators	baybridge.wealthcareportal.com	800-845-7519

Benefit Consultant– Medical		
Company	Contact	Phone Number
Heritage Companies	www.heritagekc.com	816-322-6350
Bay Bridge Administrators (Medi-Gap)	www.bbadmin.com	512-329-5069

Benefit Consultant		
Company	Contact	Phone Number
Pathway Financial Solutions	Meggy D'Arcy, Jordan Webb and Brad Veenendaal pathway125@ofgfinancial.com	785-820-8161

Tax Sheltered Accounts - 403(b) & Roth 403(b)			
Company	Agent & Phone	Company	Agent & Phone
Security Benefit Life	John Webb 888-756-6670 Jordan Webb 888-756-6670 Brad Veenendaal 888-756-6670	**Valic**	Ty Hysten 785-354-5558
American Fidelity	Wayne Ryan 800-365-1167	**Thrivent Financial**	800-847-4836
Waddell & Reed, Inc	April Barker 785-263-7496 Dean Zortman 620-646-5899 Diane Freeby 785-537-4505 Patty Kline 785-537-4505 J.W. Ward 785-238-8995 Patricia Miller 785-852-4659	**Waddell & Reed, Inc**	Paula Mueting 620-225-5903 Robert Collins 620-767-6055 Rosetta Randel 785-336-2028 Thomas Annis 785-672-3143 Tony Jennings 785-827-3606
Horace Mann Life Ins Co.	855-600-3702	**Modern Woodmen**	800-447-9811
Ameriprise Financial Services	J. Doug Jolley 785-827-8766 Lorraine McClain 785-263-0143		

KPERS		
Company	Contact	Phone Number
Kansas Public Employees Retirement System	www.kpers.org	888-275-5737

BENEFITS PROVIDED BY:

Pathway Financial Solutions, Salina, Kansas

Pathway Financial Solutions is a full service branch office of Topeka based OFG Financial Services, Inc.

John and Kelli Webb started working with school districts in 1992 providing comprehensive Sec. 125 benefits and retirement planning services to thousands of public school employees.

In 2014 Jordan Webb joined our organization, then Eddie Balluch in 2016, and Brad Veenendaal in 2021. Kelli Webb retired in 2022, but still acts as a consultant to our team. Our growth over the years has allowed us to further expand our service capabilities.

In addition to these financial professionals, we have additional customer service support with Donella Hughes, Administrative Assistant, who has been with us for more than 15 years, Amy Zeigler, Client Service Specialist, who joined our firm in 2023, and Christy Jurgensmeier, Client Service Specialist, who joined us in 2024. We also have a dedicated Section 125 specialist, Meggy D'Arcy, who joined our firm in 2022.

Our branch office currently services Sec. 125 and voluntary 403(b) plans in over 30 school districts. We also service employer matching 403(b) plans, employer prefunded 403(b) plans, and employer post retirement funding 403(b) plans in over 20 school districts.

We strive to contribute to Kansas through our memberships in various organizations, and through volunteering in our community, churches, and schools.

John Webb, Jordan Webb, Eddie Balluch, & Brad Veenendaal

120 S Santa Fe Ave
Salina, Kansas 67401
(888) 756-6670
(785) 820-8161
pathway@ofgfinancial.com
www.pathway-finanical.com

OFG Financial Services, Inc., Topeka, Kansas

Beginning in 1975, OFG Financial Services, Inc. started offering Cafeteria fringe benefit plans to public schools. This was cutting edge as it was before the Sec. 125 Cafeteria Fringe Benefit Plan law was finalized in 1978. Beginning with one school district in 1975, we have grown, and now provide Sec. 125 Plan benefits and compliance for numerous public schools and corporations in Kansas, Oklahoma, Missouri and Texas.

Our Sec. 125 plan business in the public school market has become the basis for significant growth in the Sec. 403(b) market. The servicing of, and our visibility in providing Sec. 125 benefits to our public school employees, provides a natural extension into the Sec. 403(b) market. OFG Financial Services, Inc. is a proud sponsor of KASBO, USA, KNEA, KASB and the Kansas Teach er of the Year program.