USD 475

GEARY COUNTY SCHOOLS

Learning For All • Whatever It Takes

2022 - 2023
EMPLOYEE BENEFITS

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

2022—2023 BENEFITS

USD 475 GEARY COUNTY SCHOOLS
Learning For All • Whatever It Takes

USD 475 Geary County Schools offers you and your eligible family members a comprehensive and valuable benefits program. This guide is designed to assist you in making the best choices for your needs. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

MEDICARE INFORMATION

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 29 for more details. Please read the notice carefully and keep it where you can find it. This notice has information about the prescription drug coverage offered by Geary County Schools USD 475, through Blue Cross Blue Shield of Kansas and about your options (if applicable) under Medicare's prescription drug coverage.

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

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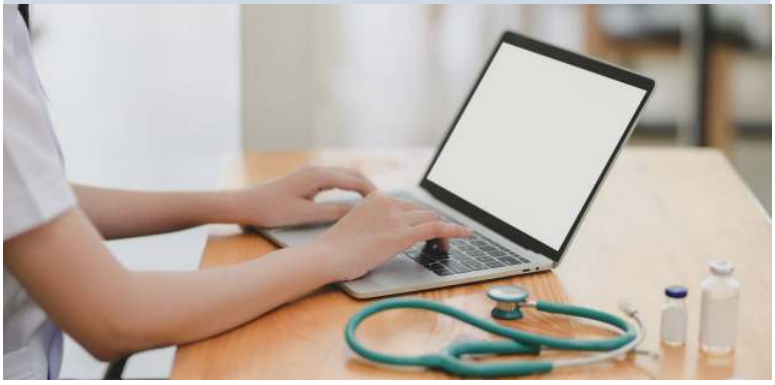


ELIGIBILITY | ENROLLMENT

Benefit Eligibility

Eligible employees and eligible family members are allowed to enroll in the benefits described in this guide. Eligible employees and family members include:

- Full-time, hourly employees regularly scheduled to work at least 30 hours per week
- Licensed personnel, (part-time based on the Negotiated Agreement)
- Legal Spouse of employee
- Children of employee, including step, adopted and foster children, and any child you have legal guardianship or court-ordered custody. Child age may vary by benefit plan. A child who is incapable of self-support due to handicap resulting from a physical condition or mental illness may be approved over the allowed child age limit.

When Does Coverage Become Effective?

- Full-time, hourly employees: first day of the month following 60-days of full-time status
- Licensed personnel: first day of the month following hire date

Qualified Life Events

IRS regulations require that, once enrolled, you may not change your benefit elections until the next open enrollment period. Outside of the Annual Open Enrollment Period, you may not make changes to your benefits unless you have certain qualified life event/change in status events. You may be asked to provide proof of the event. Qualified life events/changes in status events include:

- marriage, divorce, legal separation
- birth, adoption, legal guardianship or medical child-support order
- change in child's dependent status (i.e. reaching age 26)
- death of spouse, child or other qualified dependent
- change in residence due to an employment transfer for you or your spouse
- change in spouse's benefits or employment status that effects their eligibility status
- loss of group coverage at another plan's open enrollment
- individual becomes eligible/ineligible for Medicaid/ Medicare

PLEASE NOTE: You must notify Personnel Services of any qualified life event within 30-days of the date of the qualified event if you are requesting a change to your benefits (or 60-days if the election change event is a special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP)**.** Changes requested due to a qualified life event must be consistent with the event.

BENEFIT ENROLLMENT

Enrolling

If you are a new hire, Personnel Services will provide you with enrollment forms.

- Licensed new hires must make benefit elections within 30-days of hire date
- Full-time hourly new hires will be give the opportunity to enroll after 60-days of full-time status. Once notified of the opportunity, elections must be made within 30-days.

Elections must be made within the allotted 30-day window or you will not be eligible to elect benefits until the next annual enrollment period unless you experience a qualified life event/status change under IRS regulations.

Current employees may enroll during the annual enrollment period (during specified dates in the months of April /May). **Medical and dental elections made during the annual enrollment period will be effective July 1st. All other benefits elected during the annual enrollment period will begin June 1st.**

Contact Personnel Services with benefit related questions:
Jodie Cook
jodiecook@usd475.org
(785) 717-4016

PREMIUM CONTRIBUTIONS

You have the option under the USD 475 flexible benefits plan to elect medical, dental and vision coverage as well as the health care and dependent care flexible spending accounts. Your share of the premiums for these benefits will be deducted on a pre-tax basis. If you fail to elect coverage within the annual open enrollment or new hire eligibility period, you will be deemed to have voluntarily waived eligibility for the respective coverage for the entire year. Once made, pre-tax benefit elections are irrevocable and remain in effect for the plan year unless you have a Qualified Life Event that allows you to make a change.

MEDICALPREMIUMS

	Option 1—$500 Deductible Plan	Option 2—$1,500 Deductible Plan	Option 3—$3,000 Deductible Plan	BOE Contribution
Employee Only		Employee Contribution		
All full-time	$161.05	$140.11	$112.46	$385.00
Employee + 1		Employee Contribution		
Certified	$494.11	$448.48	$411.77	$430.00
Admin/Hourly	$444.11	$398.48	$361.77	$480.00
2 Certified Spouses	$344.11	$298.48	$261.77	$580.00
2 Admin/Hourly Spouses	$294.11	$248.48	$211.77	$630.00
1 Certified/ 1 Admin/Hourly Spouse	$304.11	$258.48	$221.77	$620.00
Family		Employee Contribution		
Certified	$749.51	$676.37	$617.52	$730.00
Admin/Hourly	$749.51	$676.37	$617.52	$730.00
2 Certified Spouses	$549.51	$476.37	$417.52	$930.00
2 Admin/Hourly Spouses	$549.51	$476.37	$417.52	$930.00
1 Certified/ 1 Admin/Hourly Spouse	$549.51	$476.37	$417.52	$930.00

Employee + 1 Tier is for coverage for the employee and one other eligible dependent (spouse or one child).
Family Tier is coverage for the employee, spouse and child(ren); or employee and two-or-more children.

DENTAL PREMIUMS

Comprehensive Dental	
Employee Contribution	
Employee Only	$31.25
Employee + 1	$59.06
Family	$99.03

Employee + 1 Tier is for coverage for the employee and one other eligible dependent (spouse or one child).
Family Tier is coverage for the employee, spouse and child(ren); or employee and two-or-more children.

VISION PREMIUMS

	Exam Only Plan	Materials Only Plan	Exam + Materials Plan
Employee Contribution			
Employee Only	$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

Employee + 1 Tier is for coverage for the employee and one other eligible dependent (spouse or one child).
Employee + Children Tier is coverage for the employee and two-or-more children
Family Tier is coverage for the employee, spouse and child(ren)

MEDICAL INSURANCE

USD 475 offers a choice of three medical plan options through Blue Cross Blue Shield of Kansas ('BCBSKS'). You have the option to seek care in or out of network with each plan; however, a higher level of benefits and your out-of-pocket costs will be substantially lower if you obtain services from participating providers and facilities. Blue Choice is the name of the provider network. Using network providers save you and the plan money! An online directory can be viewed at www.bcbsks.com; you will need to choose the **Blue Choice Preferred-Care Blue Network**.

The benefits illustrated below reflect in-network costs. The benefit plan year is July 1, 2022—June 30, 2023.

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select. **Non-Blue Choice & Non-CAP:** Difference between the payment allowance and provider charge, additional 20% coinsurance amount, deductible, coinsurance or copay amount **CAP (Non-Blue Choice):** Additional 20% coinsurance amount,* deductible, coinsurance or copay amount **Blue Choice:** Deductible, coinsurance or copay amount *Limited to a combined $2,000 per person, $4,000 two-or-more persons each benefit period.

MEMBER PAYS			
IN-NETWORK BENEFITS	**Comp. Option 1**	**Comp. Option 2**	**QHDHP Option 3**
Deductible (Per group anniversary benefit period: 7/1/2022—6/30/2023)	$500 Individual $1,000 Family	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Coinsurance (Member portion for most services)	20% of allowed amounts after deductible has been met		0% after deductible has been met
Annual Out-of-Pocket Maximum (includes copays, deductible and coinsurance)	$5,000 Individual $10,000 Family		$6,350 Individual $10,000 Family
	After the maximum out-of-pocket has been reached, eligible in-network benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.		

DOCTOR'S OFFICE VISITS		
Home, Telehealth, Office Visits, Virtual Visits (AmWell)	Primary Care Providers: $35 copay per visit Specialist Providers: $70 copay per visit	Subject to deductible
Primary Care Providers include General Practice, Family Practice, Internal Medicine, Pediatricians, and OB/Gyn. One routine Eye Exam is paid as Primary Care Provider office visit copay. Any subsequent visits paid at Specialist copay.		
Preventive care as defined by the Affordable Care Act	Paid at 100% of the allowable charge. Some of the services include: Routine screenings Preventive immunizations Well-women visits/screenings Contraceptive methods (generics)	

MEDICAL SERVICES			
	Comp. Option 1	**Comp. Option 2**	**QHDHP Option 3**
Emergency medical transportation	Subject to deductible/coinsurance		Subject to deductible
Inpatient surgery physician/surgical	Subject to deductible/coinsurance		Subject to deductible
Inpatient facility fee	Subject to deductible/coinsurance		Subject to deductible
Outpatient surgery physician/surgical	Subject to deductible/coinsurance		Subject to deductible
Outpatient lab, radiology & Advanced imaging*	Pays at 100% to a combined maximum of $300 for each covered person, each benefit period then subject to deductible/coinsurance		Subject to deductible
Emergency room	$250 copay then subject to deductible/coinsurance		Subject to deductible

*Combined benefit period maximum

BlueCross BlueShield of Kansas

MEDICAL INSURANCE

IN-NETWORK BENEFITS	Member Pays Comp. Option 1	Comp. Option 2	QHDHP Option 3
Recovery/Special Needs			
Outpatient rehabilitation	Subject to deductible/coinsurance		Subject to deductible
Hospice	Subject to deductible/coinsurance		Subject to deductible
Home health care	Subject to deductible/coinsurance		Subject to deductible
Mental/Behavioral Health			
Inpatient Services	Subject to deductible/coinsurance		Subject to deductible
Inpatient Services: Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906			
Outpatient Services	$35 office visit copay		Subject to deductible
Drug Coverage—Results Rx Drug List			
Prescription Drugs & Mail Order The prescription dug benefits include, but not limited to the following programs • Pre-authorization for certain drugs • Step-therapy • Compound-drug exclusion • Designated Specialty Pharmacy • Copay Maximization Program (Opt. 1 & 2) Drug Supply Limit—30-day supply at retail pharmacy (90-days for mail order)	$15 Generics $50 Preferred Brands $75 Non-preferred Brands $150 Preferred Specialty 20% up to $250 Non-preferred Specialty Mail order is 2 $^{1}/_{2}$ x copay with ResultsRx formulary. The quantity per prescription is a 30-day pharmacy supply or 90-day mail order supply. Specialty Drugs must be obtained through the designated specialty pharmacy Prime Specialty Pharmacy. Copay Maximization Program applies to specific Specialty Medications		Subject to deductible; if plan year deductible has been met, a copay will apply after deductible: $15 Generics $50 Preferred Brands $75 Non-preferred Brands $150 Preferred Specialty 20% up to $250 Non-preferred Specialty
Mandatory Generic— Generic medications are mandatory unless the prescription practitioner has provided the override to receive the brand name drug. If the member does not have the doctor override, the member is responsible for any cost difference above the copay. For any prescription drugs included on Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.			

This is a brief summary of the coverage available under this program. It is not a legal document. The exact provisions of the benefits and exclusions are contained in the certificate.

BCBSKS CONTRACT CHANGES—EFFECTIVE 7/1/2022

- **ACA Preventive Changes**—Colorectal screenings for cancer, that are received as an ACA preventive care service, will be covered from age 45 to 75 years of age**.** These screenings were previously covered from 50 to 75 years of age.
- **Mandatory Generics—**Generic medications are mandatory unless the doctor has provided the override to receive the brand name drug. If you do not have the doctor override, you will be responsible for any cost difference above the copay.
- **Copay Maximation 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

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.

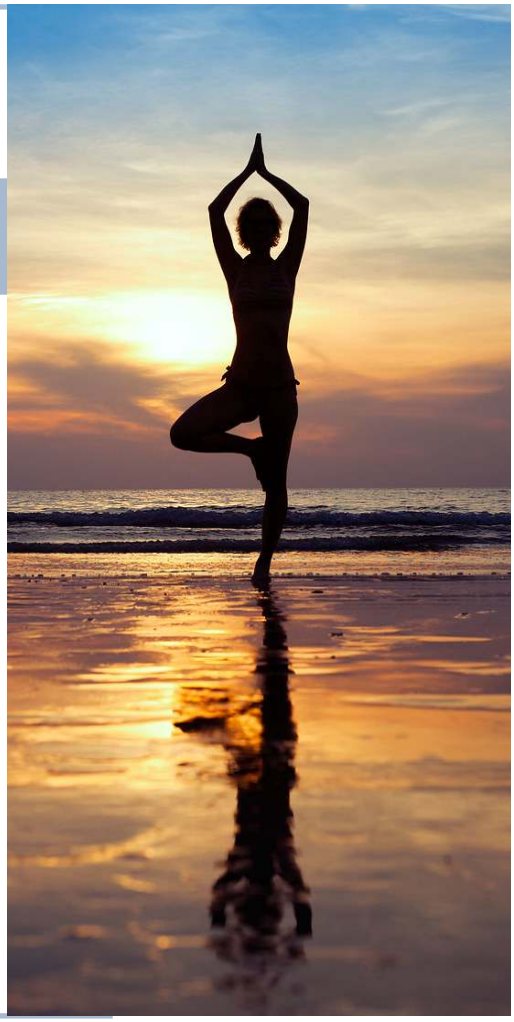
WELL-BEING WITH BCBSKS

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.



GETTING CARE

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.**

YOU MAY WANT TO VISIT…	TO TAKE CARE OF…
Your doctor's office	Routine checkups, including Preventive Care services, immunizations, managing your general health
Telehealth through AmWell	Minor health conditions such as sinus infections, urinary tract infections, respiratory conditions, bronchitis/allergies, poison ivy, pink eye, cold, flu and more
An urgent care center	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 injuries or burns

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/aca to get the latest information. For more information on health care reform and preventive services, please visit healthcare.gov

BlueCross BlueShield of Kansas

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 CONTACT

Visit: bcbsks.com/telehealth | Email: support@amwell.com | Call: (844) 733-3627

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.

2. On a computer? Visit bcbsks.com/telehealth to get started.
3. Don't have a smart phone or tablet? Call (844) SEE-DOCS

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.

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.

DENTAL INSURANCE

USD 475 offers the following comprehensive dental plan administered by Delta Dental. Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your physical health.

The maximum Benefit for all covered services for each enrolled person in any one contract year is $1,500.
The contract year is July 1, 2022—June 30, 2023

DIAGNOSTIC & PREVENTIVE SERVICES—YOU PAY 0%

DIAGNOSTIC

Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:

- Oral evaluations—two (2) times per contract year
- Bitewing x-rays—bitewings two (2) times per contract year for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over
- Full mouth x-rays or panoramic x-rays—once each five (5) years

PREVENTIVE

Provides for the following:

- Prophylaxis (Cleanings) - unlimited
- Topical Fluoride—two (2) times per contract year for dependent children under age nineteen (19)
- Sealants—once per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
- Space Maintainers—for dependent children under age fourteen (14) and only for premature loss of primary molars

BASIC SERVICES—YOU PAY 50%

- Ancillary—Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain
- Oral Surgery—Provides for extractions and other oral surgery including pre and post-operative care
- Regular Restorative Dentistry—Provides amalgam (silver) restorations, composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12)
- Endodontics—Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four(24) month period, per tooth
- Periodontics—Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis; Surgical periodontal procedures

MAJOR SERVICES—YOU PAY 50%

- Special Restorative Dentistry—When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns
- Prosthodontics—Includes bridges, partial and complete dentures; repairs and adjustments of bridges and dentures

OTHER

No deductible for any covered services
Dependent children covered to age 26

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.

DELTA DENTAL®

DENTAL INSURANCE

ENHANCED BENEFITS

Right Start 4 Kids Program
The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage, 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.

Annual Plan Maximums apply

DELTA DENTAL RESOURCES

From Delta Dental's website **www.deltadentalks.com** you can:

- Locate a participating Delta Dental Premier/PPO dentist anywhere in the United States
- Check your eligibility and plan information
- Print an ID card
- Check claim status
- Estimate your out-of-pocket dental care costs with the Flexible Spending Account Estimator
- Sign up to receive your Explanation of Benefits electronically
- Learn about oral health and wellness

Through Delta Dental's mobile app, you can:

- Use your mobile ID card
- Find a dentist
- Utilize the Dental Care Cost Estimator
- Check your coverage and claims
- And more!

To download and install the app on your device, visit the App store (Apple) or Google Play (Android) and search for Delta Dental.

You are free to go to any dentist of your choice; however, there may be a difference in the amount of payment if the dentist is not a Delta Dental participating dentist. Since nearly 4 out of 5 dentists nationwide contract with Delta Dental, the chances are excellent your dentist is already a member.

Why choose an in-network dentist?

- Discounts. Delta Dental network dentists agree to accept predetermined fees for services, which are usually discounted from typical charges. **Delta Dental PPO providers have a higher discount than Premier providers, which means your annual maximum benefit could go farther if using a PPO provider.** Delta Dental network dentists also agree not to bill patients for differences between the Delta Dental contracted fees and their typical charges.
- Only the best. All Delta Dental network dentists must meet professionally required credentialing standards. Delta Dental re-credentials providers regularly to ensure standards are maintained.

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.**

DELTA DENTAL

VISION COVERAGE

USD 475 offers a comprehensive vision plan administered through Vision Care Direct ('VCD') for you and your eligible dependents (children to age 26). The contract year is **June 1, 2022—May 31, 2023.**

Allowed benefits area available once every 12 months based on date of service. Benefits available will be determined by the vision plan you elect (i.e. Exam Only Plan, Material Only Plan or Exam + Materials Plan—see page 4 for plan premiums).

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

VISION COVERAGE

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
- Orthoptics 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

FLEXIBLE SPENDING ACCOUNTS

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 two types of FSAs available to you at USD 475:

1 **Healthcare Flexible Spending Account**
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 can increase your spendable income by an average of 30% of your annual contribution with the tax savings.

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.

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"

BAYBRIDGE MOBILE APP

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!

OTHER CONSIDERATIONS

- You can enroll in one or both accounts. Each account is a separate election.
- Over-the-counter drugs and medications and menstrual care products are now considered eligible expenses under the Healthcare FSA.
- Plan carefully when deciding how much you want to contribute to your account(s) for the year. The elections you make will remain in effect until the end of the plan year for any reason unless you experience a qualified event or termination of employment.
- Always request a detailed receipt from the provider, even when using the FSA Debit card. The IRS requires you to keep them for your tax records; and you will also need them if your FSA vendor requests substantiation that a n expense is a qualified FSA expenditure.
- The rules and regulations of the IRS govern all FSA accounts.
- FSA Plan participants (for terminated or ineligible participants) may incur claim expenses up to the date of termination/ineligibility.

FLEXIBLE SPENDING ACCOUNTS

Employees are eligible to enroll at the next open enrollment period following one year of employment. Eligible

	Health Care Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account (DCA)
Maximum Annual Election	**$2,850** Your annual election will be divided over the number of pay periods in your plan year.	**$5,000** *($2,500 if married filing separately)* Your annual election will be divided over the number of pay periods in your plan year.
Plan Year	**June 1, 2022—May 31, 2023** Expensed must be incurred during the plan year. Expenses are incurred at the time the service was provided, not when you are invoiced or pay the bill.	
How soon can you start spending your FSA funds?	With a healthcare FSA, your entire annual election amount is available on the first day of the plan year.	You will have access to your Dependent Care FSA funds that have been deducted from your paycheck.
What expenses are eligible for reimbursement?	Health plan co-pays, deductibles, co-insurance, vision care, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502)	You can use your DCA to pay for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support). Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school , summer day camp, or a nanny in your home.
How do you use the funds in your account?	If you have a benefits debit card, simply swipe it at the register. Otherwise, just file a claim including the receipt documenting the type, amount and date. Once approved, your reimbursement check will be mailed or deposited into your bank account.	Pay out-of-pocket and then file a reimbursement claim with your expense documentation.
Can you change your election amount mid-plan year?	Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.	Typically, you cannot change your contribution mid-year. However, if you experience a qualifying event, such as the birth of a new child, or if your child care provider significantly increases their rates, you may be eligible to adjust your contribution.
What happens if you don't spend all of your FSA funds by the end of the plan year?	If any balance remains in the Participant's Health FSA Account after the claim filing period, then any such balance up to $570 shall be carried over to reimburse the Participant for Health Care Expenses incurred during the subsequent Plan Year, provided that the Participant has not exercised his or her right to waive any right to any such carryover and provided that the Employer does not require an election for the subsequent Plan Year. Notwithstanding the foregoing, the Participant shall forfeit all rights with respect to any such balance above $570.	It is essential to estimate conservatively during elections. Any unused funds at the end of the plan year are forfeited, also called the use-it-or-lose-it rule.
What happens if I become an ineligible participant during the plan year?	If you terminate employment or no longer meet the plan eligibility requirements, your participation in the Health Care FSA and/or Dependent Care FSA plan will end. FSA Plan participants (for terminated or ineligible participants) may incur claim expenses up to the date of termination/ ineligibility.	

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 SERVICES

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

DISABILITY INCOME PROTECTION

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 14 days or the end of the employee's accumulated sick leave, whichever is greater	**$0.77 per $100 Monthly Benefit**
OPTION 2 Injury / Sickness 30 days or the end of the employee's accumulated sick leave, whichever is greater	**$0.62 per $100 Monthly Benefit**

CLASSIFIED EMPLOYEES

Injury / Sickness 14 days or the end of the employee's accumulated sick leave, whichever is greater	**$0.77 per $100 Monthly Benefit (Board Paid)**

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.

LIFE INSURANCE

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 Reliance Standard 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 A 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 ONE OF YOU MAY INSURE YOUR CHILDREN AS DEPENDENTS.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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. 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 a cumulative 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.

LIFE INSURANCE

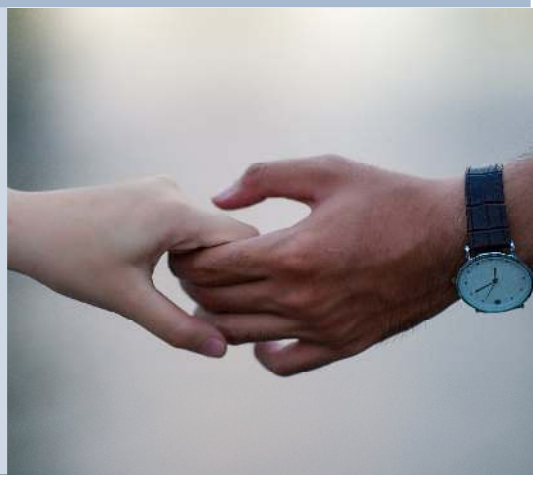
EMPLOYEE MONTHLY PREMIUM											
Age	$25K	$75K	$125K	$175K	$225K	$275K	$325K	$375K	$425K	$475K	$500K
18 to 29	$0.93	$2.78	$4.63	$6.48	$8.33	$10.18	$12.03	$13.88	$15.73	$17.58	$18.50
30 to 34	$1.38	$4.13	$6.88	$9.63	$12.38	$15.13	$17.88	$20.63	$23.38	$26.13	$27.50
35 to 39	$1.60	$4.80	$8.00	$11.20	$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

LIFE INSURANCE CONSIDERATIONS

- Your beneficiary is the person who would collect the policy amount upon your death. It is important to keep your beneficiary information up-to-date. The beneficiary cannot be changed by any person other than you—the policyholder.
- If you have life insurance policies outside of your employer you should consider reviewing those policies to make sure beneficiaries are up-to-date.
- Financial responsibilities can change throughout life—make sure you are insured for an amount that is sufficient for expenses you would not want to leave behind to your loved ones.



HUMANA CANCER & SPECIFIED DISEASE PLAN

If a serious medical event strikes, your medical insurance may help with the bills, but there are still out-of-pocket costs to contend with. In fact, 75% of insured people who had problems paying medical bills said their co-pays, deductibles or co-insurance cost more than they could afford. The Humana Cancer and Specified Disease plan is a smart way to be prepared no matter what comes your way.

Cancer and specified disease insurance can help when life throws the unexpected your way. If you're diagnosed with a covered illness like cancer or you encounter certain catastrophic health events, your plan can pay a lump-sum benefit directly to you, to use however you need.

Benefit	BBAC—0001	BBAC—0352
Wellness benefit	up to $50 per year	up to $100 per year
First Diagnosis Benefit	$2,500	$7,500
Hospital Confinement	$100 per day	$200 per day
Surgery	up to $1,500	up to $4,500
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy	up to $1,000 per day	Up to $5,000 per month
Colony Stimulating Factors	up to $500 per month	up to $1,000 per month
Positive Diagnosis Test	Up to $300 per year	Up to $300 per year
Second and Third Surgical Opinions	Actual charges	
Non-Local Transportation	Actual charges or $0.50 per mile if a personal vehicle is used	
Adult Companion Lodging and Transportation	up to $75 per day for lodging; $0.50 per mile if A personal vehicle is used	
Ambulance	Actual charges	
Donor Benefit Bone Marrow and Stem Cell Transplant	$200 per day for medical expense; Actual charges for round-trip coach fare; or personal automobile expense of $0.50 per mile; up to $50 per day for lodging and meals	
Bone Marrow and Stem Cell Transplant	Up to a combined lifetime max of $15,000	
Anesthesia	up to 25% of surgical benefit paid	
Ambulatory Surgical Center	$250 per day	
Drugs and Medicines	up to $25 per day; $600 per calendar year	
Outpatient Anti-Nausea Drugs	up to $250 per year	
Miscellaneous Therapy Charges	up to a lifetime max of $10,000	
Self-Administered Drugs	up to $4,000 per month	

HUMANA CANCER & SPECIFIED DISEASE PLAN

Benefit	BBAC—0001	BBAC—0352
Blood, Plasma and Platelets	up to $200 per day	
Physician's Attendance	up to $35 per day	
Private Duty Nursing Service	up to $100 per day	
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit	up to $750 for evaluation; up to $350 for lodging and transportation	
Breast Prosthesis	Actual charges	
Artificial Limb or Prosthesis	$1,500 lifetime max per amputation	
Physical or Speech Therapy	up to $35 per session	
Extended Benefits	$300 per day	
Extended Care Facility	up to $50 per day	
At Home Nursing	up to $100 per day	
New or Experimental Treatment	up to $7,500 per calendar year	
Hospice Care	up to $50 per day	
Government or Charity Hospital	$200 per day	
Hairpiece	up to a lifetime max of $150	
Rental or Purchase of Durable Goods	up to $1,500 per calendar year	
Waiver of Premium	After 60 days	

OTHER SPECIFIED DISEASES COVERED

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Malaria
- Meningitis
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

HUMANA CANCER & SPECIFIED DISEASE PLAN

Individual Cancer Plan Monthly Premium				
BBAC-0001	**0-29**	**30-44**	**45-59**	**60+**
Employee	$7.49	$15.26	$32.35	$47.03
1 Parent Family	$13.84	$21.60	$38.83	$52.60
2 Parent Family	$15.94	$30.94	$64.38	$93.15
BBAC-0352	**0-29**	**30-44**	**45-59**	**60+**
Employee	$13.09	$24.96	$52.86	$79.11
1 Parent Family	$23.97	$35.85	$63.97	$88.47
2 Parent Family	$27.67	$51.09	$105.94	$157.14
$325 Intensive Care Rider	**0-29**	**30-44**	**45-59**	**60+**
Employee	$1.48	$2.59	$3.24	$3.61
1 Parent Family	$3.02	$4.13	$4.80	$5.18
2 Parent Family	$3.70	$5.78	$6.89	$6.53
$625 Intensive Care Rider	**0-29**	**30-44**	**45-59**	**60+**
Employee	$2.85	$4.99	$6.22	$6.95
1 Parent Family	$5.80	$7.94	$9.23	$9.96
2 Parent Family	$7.12	$11.12	$13.25	$12.56
$725 Intensive Care Rider	**0-29**	**30-44**	**45-59**	**60+**
Employee	$3.30	$5.79	$7.22	$8.06
1 Parent Family	$6.73	$9.21	$10.71	$11.55
2 Parent Family	$8.25	$12.90	$15.37	$14.57
$825 Intensive Care Rider	**0-29**	**30-44**	**45-59**	**60+**
Employee	$3.76	$6.58	$8.21	$9.17
1 Parent Family	$7.66	$10.48	$12.19	$13.15
2 Parent Family	$9.39	$14.67	$17.49	$16.58

403(b)RETIREMENT SAVINGS PLAN

USD 475 offers a 403(b) Retirement Savings Plan to employees of the district. You are eligible to join this plan on your date of hire and as specified by Geary County Schools USD 475.

403(b) CONTRIBUTIONS

This plan provides for pre-tax salary reduction contributions, post-tax Roth salary reduction contributions, and rollovers. There are no employer contributions.

- You may transfer benefits from a former employer's eligible retirement plan into this plan.
- You can contribute up to 100% of your compensation to this plan up to the limit allowed under the IRS
- If you are age 50 or older you can contribute a "catch-up" contribution up to $6,500 (amount subject to change based on the annual contribution limits set by IRS each year)
- 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 USD 475, without respect to your years of service
- Automatic payroll deductions withdraw your contributions directly from your paycheck after you complete a Salary Reduction Agreement and return it to Personnel Services. You may change your contributions any time by modifying your Salary Reduction Agreement

PRE-TAX 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 CONTRIBUTIONS

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 $59^1/_2$, die, or become disabled and have held the Roth account for 5 years at the time of its distribution from this plan.

INVESTMENTS OPTIONS

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 on the Bay Bridge website, http://sfr.baybridgeadministrators.com

You select how you want your contributions to be invested. Your custodial account or annuity contract will determine how often you may change your investment mix. Please see a list of investment providers on the contact page of this Benefit Guide

KPERS BENEFITS

LONG-TERM DISABILITY

KPERS long-term disability benefits provide income protection if you cannot work because of an illness or injury. If you become disabled, you may qualify for a disability benefit based on 60% of your annual salary. You must be disabled 180 days and no longer receiving employer compensation. The minimum monthly benefit is $100 and the maximum is $5,000.

BASIC TERM-LIFE INSURANCE

USD 475 Geary County Schools provides eligible employees with basic term life coverage at no cost to you. Enrollment is automatic through KPERS. The benefit is equal to 1 1/2 times your base annual earnings to a maximum of $250,000.

OPTIONAL TERM-LIFE INSURANCE

You may choose to purchase optional life insurance, up to $250,000. you pay the total cost of this benefit through a convenient payroll deduction. This coverage is an addition to the coverage already provided to you just by being a KPERS member.

JOB-RELATED DEATH BENEFIT

If you die from a job related accident, your spouse will receive a monthly benefit based on 50% of your final average salary, less any Workers' Compensation. The Retirement System also returns your contributions and interest if you die. You can name different beneficiaries for these benefits.

KPERS

LEGAL NOTICES

CONTINUATION OF HEALTH PLAN COVERAGE

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

IT IS VERY IMPORTANT THAT YOU NOTIFY PERSONNEL SERVICES IF YOU EXPERIENCE A DIVORCE/LEGAL SEPARATION OR HAVE A DEPENDENT WHO NO LONGER MEETS THE ELIGIBILITY RULES OF THE PLAN.

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

NOTICE OF SPECIAL ENROLLMENT PROVISIONS

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

HIPAA PRIVACY

The Company Medical Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by USD 475 is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through Personnel Services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

SPECIAL RULES FOR MOTHERS AND NEWBORNS

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

LEGAL NOTICES

NOTICE OF CHIPRA POLICY

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in the State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan.

This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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

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

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

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law took effect in 2014, it established a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

Is My Current Health Insurance Coverage Changing Through My Employer?

NO. The Health Insurance Marketplace is another option for obtaining health insurance coverage.

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.

What is the Health Insurance Marketplace?

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

LEGAL NOTICES

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 9.61 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

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

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

Employer Name: Geary County Schools USD 475
Employer EIN: 48-6019142
Employer Address/Phone: 123 N Eisenhower
Junction City, KS 66441 | (785) 717-4016

Who Can We Contact About Employee Health Coverage at This Job? Personnel Services

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

- As your employer, we offer a health plan to:
  Full-time hourly employees regularly scheduled to work 30 or more hours per week and licensed personal (part-time based on negotiated agreement)

- With respect to dependents:
  We do offer coverage. Eligible dependents are: Legal Spouse and Children of employee, including step, adopted and foster children, and any child you have legal guardianship or court-ordered custody. Child age may vary by benefit plan. A child who is incapable of self-support due to handicap resulting from a physical condition or mental illness may be approved over the allowed child age limit.

  This coverage is intended to meet the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Geary County Schools USD 475 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Blue Cross Blue Shield of Kansas has determined that the prescription drug coverage offered by Geary County Schools USD 475 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 Geary County Schools USD 475 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 Geary County Schools USD 475 coverage, be aware that you and your dependents will 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 Geary County Schools USD 475 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.

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: Geary County Schools USD 475
Contact--Position/Office: Personnel Services
Address: 123 N. Eisenhower | Junction City , KS 66441
Phone Number: (785) 717—4016
Print Date: April 2022

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).

CONTACT INFORMATION

PERSONNEL SERVICES

Jodie Cook
jodiecook@usd475.org
(785) 717-4016

Employee Customer Service Contacts		
Company	**Website**	**Phone Number**
Medical **Blue Cross Blue Shield of Kansas**	www.bcbsks.com	Member Services: 800-432-3990 Specialty Pharmacy: 833-721-1620
Dental **Delta Dental of Kansas**	www.deltadentalks.com	800-234-3375
Vision **Vision Care Direct**	members.visioncaredirect.com	877-488-8900
Flexible Spending Accounts **Bay Bridge Administrators**	https://baybridge.wealthcareportal.com	800-845-7519
Employee Assistance Program **Pawnee Mental Health Services**	www.pawnee.org	785-762-5250 Junction City 785-243-8900 Concordia 785-587-4300 Manhattan

Tax Sheltered Accounts – 403(b)				
Company	**Contact**			
Security Benefit Life	John & Kelli Webb	888-756-6670	Jordan Webb	888-756-6670
American Fidelity Assurance Co	Wayne Ryan	800-365-1167		
Horace Mann Life Ins Co	Parker Malonado	316-260-9203	Rod Myers	316-788-2894
Waddell & Reed	April Barker	785-263-7496	Paula Mueting	620-225-5903
	Dean Zortman	620-646-5988	Robert Collins	620-767-6055
	Diane Freeby	785-537-4505	Rosetta Randel	785-336-2028
	Patty Kline	785-537-4505	Thomas Annis	785-672-3143
	J.W. Ward	785-238-8995	Tony Jennigs	785-827-3606
	Patricia Miller	785-852-4659		
Valic	Ty Hysten	785-274-8699		
Modern Woodmen		800-447-9811		
Ameriprise Financial Services, Inc.	J. Doug Jolley	785-827-8766	Lorraine McClain	785-263-0143
Thrivent Financial for Lutherans	Thrivent Financial	800-847-4836		

BENEFIT CONSULTANTS

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Jennifer.Summervill@bbrown.com | (316) 448-5118

Ancillary Services (FSA, Cancer, Vision, Life and Disability)
OFG Financial Services, Inc
Kelli Webb & Jordan Webb
Pathway Financial Solutions | (888) 756-6670

USD 475 GEARY COUNTY SCHOOLS

123 N Eisenhower
Junction City, KS 66441
(785) 717-4000

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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