Odessa R-VII School District

2017 Open Enrollment

2017 Annual Benefit Enrollment News

July 1, 2017 marks the renewal of your employee benefit plans. As you are aware, we faced a very challenging renewal for 2016. We knew going into our renewal for 2017 that it was going to be yet another challenging year. Because of that we proactively sought out bids from the market for our medical plans. As a result of the bidding process, it was determined that we will move our medical plans to Humana effective July 1, 2017. By doing this, we were able to provide a premium savings to you of over 20%. Some things to take note of as we go through this transition:

1) We did an analysis of the top 30 providers currently being utilized by our group and compared that to Humana's provider network. There was a high match rate for Primary Care Physicians and Specialists. That said, it is highly recommended that you visit www.humana.com or call 1-800-448-6262 to see if the provider you are using today is in the Humana Choice Care network.

2) If you or a family member are receiving care from a provider that is not in the Humana network, we encourage you to complete Transition of Care form on page 31. This form helps Humana determine if they can temporarily authorize care from an out-of-network provider, while paying charges at the in-network level. This form must be complete and received by Humana within 90 days of July 1, 2017.

3) While we did our best to match your current plans as closely as possible, there will be differences in our plans. A couple of changes to note:
   a. We will no longer offer a HMO plan. The Buy-Up PPO plan was built to closely mirror the HMO.
   b. Deductible and Out-of-Pocket maximums will increase.
   c. Office visit/Urgent Care/Emergency Room copays (if applicable) will change.
   d. Prescription Drugs will change substantially. If you are on a prescription today, it will be very important that you pay attention to what tier your prescription falls in, and if it is a specialty drug, know that that you are responsible for a percentage of your drug up to the maximum indicated.

4) We negotiated with Humana to provide members currently enrolled on the PPO or QHDHP deductible credit for any expenses incurred prior to July1, 2017. A file will be provided by BCBS to Humana on June 15th with deductible credit amounts. That file will capture the majority of the claims, but there will be some claims that haven't been processed. It will be important that if you receive services on or after June 15th that you provide your most current BCBS Explanation of Benefits to Humana after the July 1 effective date. This does not apply to current HMO members.

5) We have partnered with Premier Worksite Solutions to provide an electronic enrollment solution to the district at no cost. Not only will this system eliminate paper enrollment, but it will provide one-on-one enrollment sessions to assist you with your enrollment, and answer an outstanding questions you may have. This process has been very successful at many school districts, and the general feedback from employees is that they are walking away from their enrollment with a greater understanding and appreciation of their benefit options.

6) We will continue to offer Voluntary Income Protection, Cancer, Critical Illness, Accident, and Hospital Confinement plans. If you currently have an Aflac policy you will be able to continue that coverage and pay for it via payroll deduction as you have in the past. Any new policies issued and paid via payroll deduction will be through Colonial. You can see a brief overview of those products on pages 17 and 18.

7) We would like to offer you the opportunity to take advantage of Prudential's free onsite Pathways Financial Seminar Series. Prudential Pathways Seminars are easy-to-understand seminars and are designed to boost your confidence and skills to pursue your financial goals. The seminars listed on page 19 will be offered in the coming school year and will require a minimum of 10 participants. So that we are able to gauge interest, please indicate on the worksheet at the end of this guide if you have a general interest in this service.

How to Enroll, Waive, and Confirm Benefits

Our July 1, 2017 open enrollment will begin April 24th and run through April 28th. Everyone must complete the one-on-one enrollment process during this time. Failure to complete your online enrollment April 28th will result in no coverage.

One-on-One Enrollment will require that you schedule an appointment on the date enrollers are in your building. Please allow approximately 30 minutes for your enrollment session. We strongly encourage you to complete the worksheet at the end of this guide and bring it to your enrollment session. Not only will this expedite your enrollment session, it will also ensure that you have all necessary information, including social security numbers, to complete your enrollment.

You may schedule your enrollment session by clicking the green button below.

High School | McQuerry Elementary

Middle School | Upper Elementary

Admin

Open Enrollment Meeting

CBIZ and Humana will hold a benefit enrollment meeting to review the benefits available to you during on the following dates:

Upper Elementary – April 19th @ 2:45pm

Middle School – April 20th @ 7:00am

McQuerry Elementary – April 20th @ 3:10pm

High School – April 21st @ 7:15am

Healthcare Consumerism Tools & Resources

Being a knowledgeable healthcare consumer when using any of your benefits, including medical, dental and vision care, is an integral part of controlling your personal healthcare budget, as well as the District's overall benefit claims cost. We want to make sure you are aware of, and using the various healthcare tools and resources made available to you.

New Resources Available to You

Medical Insurance video links for better consumerism:

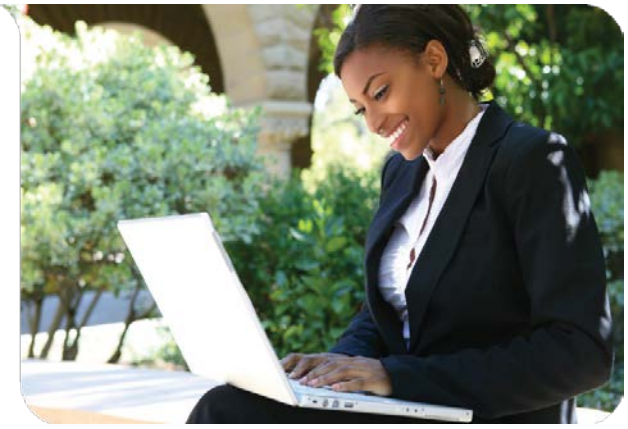
- My Humana Website
- Humana Pharmacy
- Humana Pharmacy Mobile App
- Go365

MyHumana

Register now at Humana.com

Find your personalized health and benefits information in one place – MyHumana

As a Humana member, you have a secure website on Humana.com called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information, planning tools, and wellness resources.



Some of what you can do on MyHumana:

- Claims – Check if a claim has been paid along with your estimated cost, if any
- Coverage details – Review deductibles, coverage levels, and limits
- Provider search – Use Physician Finder Plus to find in-network providers near you
- Humana's MyChoice Tools℠ – Choose providers wisely and estimate costs
- Drug Pricing – Look up coverage, estimated prices, and possible alternatives
- Rx Calculator – Plan for out-of-pocket drug costs
- Health and Condition Centers – Access health information specific to your conditions and life stage
- Year-to-Date Summary – See an at-a-glance view of your financial information – including balances in your Health Savings Account, Flexible Spending Account, or Personal Care Account and amounts applied to deductibles
- Manage access – Give other adults on your policy permission to access your health information
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them – via paper or e-mail

Registering is easy

- Have your Humana ID card ready
- Go to Humana.com
- Select "Register" at the top of the page or in the log-in box on the left
- Choose "Member all other plan types"
- Fill in some basic information – like your member ID number, date of birth, ZIP code, and e-mail address, and click "next"
- Create a User ID, password, and security prompt and click "next" to finish

Now, how easy was that? You're all set – jump in and start exploring!

You don't have to wait for health and benefits guidance – you can get it right away with MyHumana.

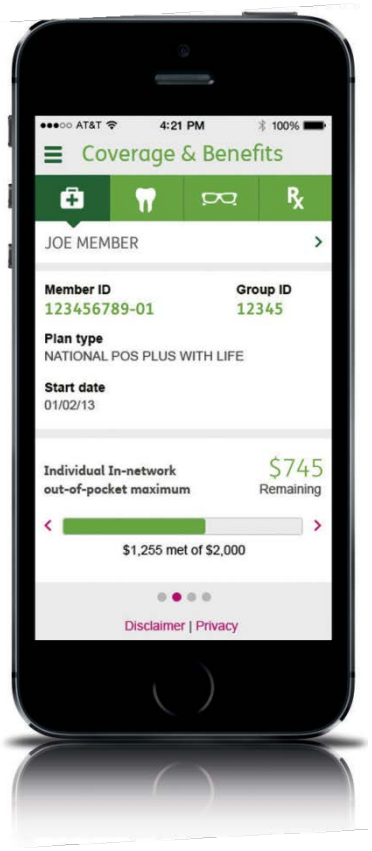
Please note, all features may not be available to all members.

Humana®

Humana.com

MyHumana Mobile app

"Now we go where you go"



Access your health information anytime, anywhere

Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision, and pharmacy claims
- View your plans and coverage details
- View your HumanaVitality® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your RightSource® prescriptions

Download the Mobile App:

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play or App Store.

Download on the App Store

ANDROID APP ON Google play

From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign-in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or Sign in
2. Click on the Menu icon
3. Select Text Alerts
4. Register and verify your Mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or Sign in
2. Click on Account settings & preferences
3. Select Edit your preferences
4. Select Mobile from the tab
5. Register and verify your Mobile #
6. Select the alerts you want to receive

†Available to HumanaVitality members only.

*Message and data rates may apply.

Humana®

Humana.com

Convenience Care

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to the deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit our website at www.humana.com.

Urgent Care

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room.

We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at www.humana.com.

Emergency Room

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

If you obtain care at an emergency room, you will likely pay more out-of-pocket than if you were treated at your doctor's office, a Convenience Care Center or Urgent Care Facility.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once the condition has been stabilized.

Convenience Care Center

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Urgent Care

Typical conditions that may be treated at an Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Back Pain or Strains
- Small cuts
- Sore throats
- Rashes
- Preventative Screenings

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Emergency Room

Some examples of emergency conditions may include the following:

- Heavy bleeding
- Chest pain
- Sudden change in Vision
- Major burns
- Sudden weakness head injuries
- Large open wounds
- Spinal injuries
- Difficulty breathing
- Severe head injuries

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

Medical Plan

Odessa R-VII will continue to offer three medical plans through Humana. As a reminder:

1) We will no longer off a HMO
2) We recommended that you visit www.humana.com or call 1-800-448-6262 to see if the provider you are using today is in the Humana Choice Care Network.
3) If you are on a prescription today, it will be very important that you pay attention to what tier your prescription falls in, and if it is a specialty drug, know that that you are responsible for a percentage of your drug up to maximum indicated.
4) If you or a family member are receiving care from a provider that is not in the Humana network, we encourage you to complete the Transition of Care form on page 31.

Humana®

At www.myhumana.com you will have the ability to:

- Find Doctors & Hospitals
- Check Claim Status
- Choose Providers & Estimate Costs
- Access Rx Calculator
- View Benefits

	QHDHP	BASE PPO	BUY-UP PPO
Deductible - Individual - Family	 $4,000 $8,000	 $3,000 $6,000	 $0 $0
Coinsurance	0%	20%	0%
Out of Pocket (OOP) Max - Individual - Family	$4,000 $8,000	$6,500 $13,000	$5,000 $10,000
Physician Office Visits - PCP - Specialist	 Subject to Ded. Subject to Ded.	 $30 $55	 $25 $55
Hospital Services - Inpatient - Outpatient surgical	 Subject to Ded. Subject to Ded.	 Ded. then 20% Ded. then 20%	 $500 per day up to $1,500 $500
Emergency Room	Subject to Ded.	$150	$350
Urgent Care	Subject to Ded.	$100	$100
Prescription Drugs - Deductible		N/A	N/A
- Tier 1 Generic - Tier 2 Preferred - Tier 3 Non-Preferred - Tier 4/Specialty @ Humana Pharmacy @ network non-Humana Pharmacy	All prescriptions Subject to Deductible	$10 $35 $55 25% up to OOP max 35% up to OOP max	$10 $35 $55 25% up to OOP max 35% up to OOP max
- Mail order		$25/$87.50/$137.50/25%	$25/$87.50/$137.50/25%

The Medical Plan chart above is for illustrative purposes only and does not include all benefits, plan limitations, and/or exclusions. This represents in-network benefits only. Please refer to the Humana summary for greater detail. In the event there is a discrepancy in benefits, the carrier benefit summary/SPD will always govern.

Medical Plan Cost

Below are the employee costs for each plan per month. These rates assume your participation in the District's wellness program requirements. Employees that did not complete the wellness program requirements will contribute an additional $20 in monthly premium for all plan options.

	QHDHP		BASE PPO	BUY-UP PPO
	Employee Cost	District HSA Contribution	Employee Cost	Employee Cost
Employee Only	$0	$91.50	$0	$55.03
Employee + Spouse	$497.20	$91.50	$588.71	$698.78
Employee + Child(ren)	$522.06	$91.50	$618.15	$730.97
Family	$904.91	$91.50	$1,071.46	$1,226.65

Health Savings Account (HSA)

How does the QHDHP work?

The office visit copay is eliminated in this plan. All charges related to diagnostic office visits and hospital services will apply to your deductible. Routine Preventive Care is covered 100%, not subject to the deductible. The plan provides 100% coverage in-network after the deductible is met, so all remaining charges are paid in full.

Prescription drugs also apply to the medical plan deductible. After the full deductible is met they are paid at 100% for the remainder of the year.

If you remain in-network, you will still benefit from the Humana contracts with their network providers. Only the discounted "allowable" amount will apply to your deductible, not the full billed charge. Contracted discounts average 40-50% savings.

Your deductible is offset by reduced premiums and the contributions you and the District make to your HSA. These funds roll over year to year, and can eventually provide full reimbursement of all out-of-pocket costs.

Health Savings Accounts (HSA): Optum

Over the last several years, you have probably heard a lot about the concept of consumer driven health care. As health insurance costs have continued to increase due to an aging population, state-of-the-art technology, increased cost and prescribing of prescription drugs, and greater occurrence of “lifestyle-related” conditions, the savings once achieved through tightly managing health care delivery has been outpaced by inflation and rejected by consumers who demand more freedom. There are two parts to this plan. The medical plan (QHDHP) and the banking piece (HSA).

Part one, the QHDHP, will have a $4,000 Individual/$8,000 Family Deductible. Every service, including prescription drugs, will go toward the Deductible. Once you have satisfied the Deductible amount, all medical services will be paid at 100% for the remainder of the plan year.

Your QHDHP is accompanied by part two, a Health Savings Account (HSA). If you participate in the QHDHP, you can set aside money in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. An HSA is similar to a flexible spending account in that you are eligible to pay for health care expenses with pre-tax dollars. There are several advantages of an HSA. For instance, money in an HSA can be invested much like 401(k) funds are invested. Unused money in an HSA account is not forfeited at the end of the year and is carried forward. Also, your HSA account is yours to keep which means that you can take it with you if you change jobs or retire.

Who is eligible to participate in a HSA?

You are eligible to participate in a HSA if you are covered by a QHDHP. Employees, dependent spouses and/or children who are covered by any non-qualified plan, including Medicare, are not eligible for the HSA.

You are ineligible if you and/or your spouse are contributing to a Section 125 FSA plan that is not a LIMITED FSA. You may have a Dependent Day Care Expense Account or participate in the Premium Savings program – these will not disqualify you.

How much can I contribute to my HSA?

The maximum amount that you can contribute to a HSA for the 2017 calendar year max is $3,400 for individual coverage and $6,750 for family coverage. Additionally, if you are age 55 or older, you may make an additional “catch-up” contribution of $1,000. **This maximum is a combined total of the District and employee contributions. The District will fund $91.50 per month ($1,098 annually) for the 2017-2018 plan year.**

What are some of the advantages of a HSA?

What is an HSA

Less monthly premium paid on a QHDHP allows for discretionary employee and District contributions into a personal Health Savings Account, which is then used to offset the cost of your healthcare services.

You may use the HSA funds for the same type of things covered by a Section 125 Flexible Spending Account (e.g. dental, vision, and prescription drug out-of-pocket costs), and some things which the Section 125 plan does not allow: COBRA premium, Employee health insurance premium other than Medicare supplement policies, Long Term Care insurance premiums, and health insurance premiums if you are receiving unemployment.

With the HSA, you have a triple tax advantage: contributions are tax-deductible (no Federal, State, or Employment taxes are deducted), earnings on your balance and investments are not taxed, and funds withdrawn for qualified medical expenses are not taxed.

The money in the HSA is always yours to use – even if you change back to a traditional medical plan at open enrollment, retire or leave the District. If you own an HSA account and later enroll in a non-qualified plan, you will no longer be able to contribute to the HSA, but your account will continue to accumulate interest. You may also withdraw from the account for qualified medical expenses for you and your dependents.

If you are currently enrolled in a Flexible Spending Account (FSA) and intend to enroll in the QHDHP you **MUST** zero out your FSA before you establish your HSA. Due to IRS regulations, you cannot have a FSA and contribute to a HSA at the same time.

If you are currently enrolled in a traditional plan (HMO or PPO) and you intend to enroll in the QHDHP you cannot use your HSA funds for expenses incurred prior to enrolling in the QHDHP.

Please remember – you are not eligible to set up a HSA if you OR your spouse has a Medical Expenses FSA account or secondary insurance coverage such as another employer's group medical plan, individual medical coverage, Medicare, or Tricare.

An HSA works much like an IRA. The money is yours, and rolls over year to year, accumulating as you age, as you move from employer to employer, and from one QHDHP to another. Depending on the HSA vendor, you may be able to direct how those funds are invested.

Contributions and investment earnings are tax-free, as are disbursements from the account to pay for qualified expenses. Funds withdrawn for non-qualified expenses will be assessed a 20% penalty in addition to normal taxation. The penalty is waived in the event of death, disability, or attainment of Medicare eligible age

Flexible Spending Accounts (FSA)

Types of Accounts

Part 1) Pre-tax Premiums

Your premium contributions for medical, dental, vision, and some other insurance coverage are eligible to be run through the Section 125 plan on a pre-tax basis – allowing additional tax savings and increasing your take-home pay.

Part 2) Healthcare Flexible Spending Account (FSA)

The district provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed you can roll over up to $500 to the next plan year. The maximum that you can contribute to the FSA is $2,550. All the funds are available day one of the plan year.

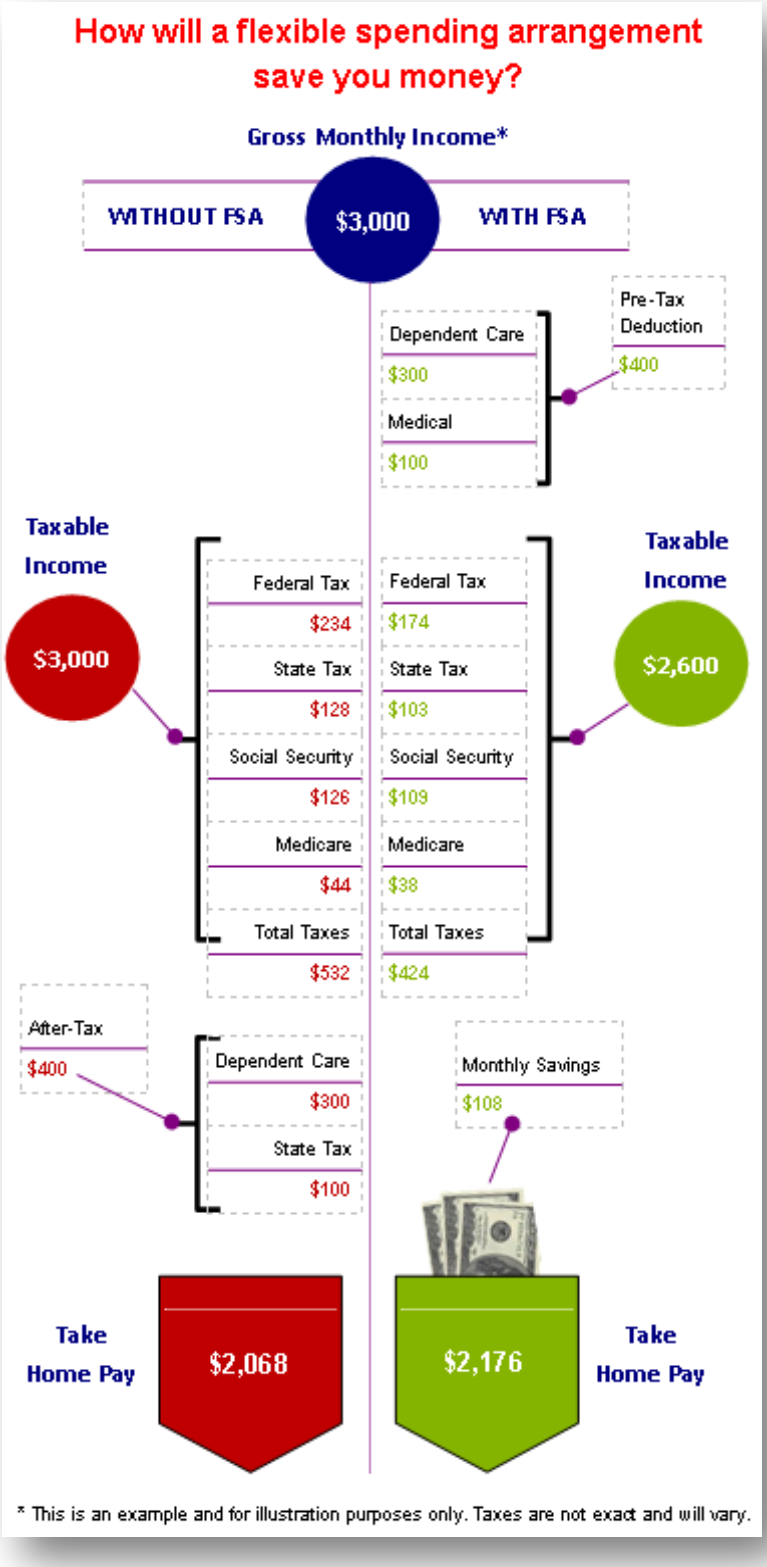
Part 3) Dependent Daycare Account

A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work. The contributions to your dependent daycare account come out of your paycheck before any taxes are taken out. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

The maximum that you can contribute to the Dependent Care Flexible Spending Account is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately. The funds you contribute to this account are available within 3-5 days after each payroll deduction.

Flexible Spending Accounts (FSA) (Cont'd)

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.	
Alcoholism treatment	Laboratory fees
Artificial limbs	Licensed osteopaths
Ambulance	Licensed practical nurses
Braces	Orthodontia
Chiropractors	Orthopedic shoes
Coinsurance and copayments	Obstetrical expenses
Contact lens solution	Oxygen
Contraceptives	Prescription drugs
Crutches	Podiatrists
Deductible amounts	Prescribed vitamin supplements (medically necessary)
Dental expenses	Psychiatric care
Dentures	Psychologist expenses
Dermatologists	Routine physical
Diagnostic expenses	Seeing-eye dog expenses
Eyeglasses, including exam fee	Smoking cessation programs
Handicapped care and support	Sterilization and reversals
Nutrition counseling	Substance abuse treatment
Hearing devices and batteries	Surgical expenses
Hospital bills	



Dental Plan

The dental benefits will continue to be offered through Delta Dental of Missouri. There are no plan or rate changes effective July 1, 2017.

You have two plans to choose from, both of which offer coverage for preventive, basic and major services. To maximize your benefits you will want to use a participating dentist in the PPO or Premier network.

You can find a list of participating dentists at www.deltadentalmo.com or call 1-888-989-8842. Services, such as semi-annual cleanings, are covered at 100% with no member copay.

Dental Insurance video links for better consumerism:

Why it pays to stay In-Network

The Many Ways Dental Benefits Pay

Your Explanation of Benefits Explained

	BASE		BUY-UP	
	PPO	Premier or Non-Network	PPO	Premier or Non-Network
Deductible				
- Individual - Family - Waived for Preventive	$50 $150 Yes		$50 $150 Yes	
Coinsurance				
- Preventive - Basic - Major - Ortho	100% 80% 50% 50%	80% 80% 50% 50%	100% 90% 60% 60%	100% 80% 50% 50%
Maximum Benefits				
- Annual - Ortho	$1,000 $1,000		$1,500 $1,500	

This is only a summary. Please refer to your specific book/certificate for specific details. If a conflict arises, the booklet/certificate will govern in all cases.

Dental Plan Cost

	Employee Cost Per Month	
Employee Only	$35.29	$44.03
Employee + Spouse	$69.11	$86.24
Employee + Child(ren)	$99.90	$124.52
Employee + Family	$133.57	$166.68

Vision Plan

The vision benefits will continue to be offered through Superior Vision. There are no plan or rate changes effective July 1, 2017.

To identify participating providers, you may go to www.superiorvision.com or 1-(800)-507-3800.

Vision Insurance video for better consumerism:

Odessa School District Superior Vision Plan

Why Superior Vision

Member Portal Webinar

Find an In-Network Provider

What makes Us Superior

Superior Vision	
Copays	
- Exams - Materials - Contact Lens Fitting Fee	$10 $25 $15
Frequency Limitations	
- Exams - Lenses - Frames - Contact Lens	Once every 12 months Once every 12 months Once every 24 months Once every 12 months
Reimbursement Schedule	
- Glass Lenses - Single - Bifocal - Trifocal - Contact Lenses - Medically Necessary - Elective - Frames Standard	 100% 100% 100% 100% Up to $120 Up to $130

This is only a summary. Please refer to your specific book/certificate for specific details. If a conflict arises, the booklet/certificate will govern in all cases.

Vision Plan Cost

	Employee Cost Per Month
Employee Only	$8.93
Employee + One	$15.17
Employee + Family	$25.19

Basic Life/AD&D Plan - Prudential

Talk to Pete - Life

Talk to Pete AD&D

Prudential Micro-Site

EZ Life Needs Calculator

Odessa School District provides a basic $25,000 term life insurance benefit at no cost to you. Additionally, you will receive Accidental Death and Dismemberment (AD&D) coverage in the amount of $25,000. Please be sure your beneficiary information is up to date for all life insurance coverage.

Voluntary Life Plan - Prudential

You may also elect to purchase an additional amount of supplemental life insurance on yourself and your dependents, subject to medical underwriting. Employees may select supplemental coverage in increments of $10,000 up to the lesser of 7 x your annual earnings or $500,000. During the open enrollment period, employees currently enrolled may purchase up to $40,000 more in coverage without proof of good health/evidence of insurability. If you wish to purchase more than these amounts, you will need to request an Evidence of Insurability form from Linda Eberhardt. Newly eligible employees wishing to enroll in the supplemental life insurance plan for the first time may purchase up to $40,000 worth of coverage without completing proof of good health. For amounts over $40,000 you will need to request an Evidence of Insurability form from Linda Eberhardt.

You may also elect to purchase supplemental life insurance coverage for your spouse and/or dependent children, up to the age of 19 or 25, if a full-time student. For your spouse you elect coverage in $5,000 increments, not to excess 50% of your coverage amount. Children can be covered for a benefit of $10,000 beginning at 14 days old. To increase the current amount of dependent coverage, you will need to request an Evidence of Insurability form from Linda Eberhardt.

All dependent children can be covered for the $10,000 benefit at a cost of just $0.91 per month, regardless of the number of children covered.

Age	Employee & Spouse Rates per $1,000
< 25	$0.042
25 – 29	$0.051
30 – 34	$0.068
35 – 39	$0.076
40 – 44	$0.085
45 – 49	$0.127
50 – 54	$0.195
55 – 59	$0.365
60 – 64	$0.560
65 – 69	$1.079
70 +	$1.749

Colonial Life

Video Links for Better Consumerism Tools

Cancer Insurance | Income Protection | Critical Illness | Accident Insurance | Hospital Confinement

Income Protection – Colonial

Policy Features

- Several different benefit plan options
- Solution for short term leaves such as Maternity leave
- Benefit payments deposited directly into your bank account
- Benefits are payable year-round
- Guarantee Issue (no medical question)

Is your paycheck protected?
Help protect your paycheck in the event of a disability with an Income Protection plan. This plan may help provide financial protection if you become disabled and cannot work due to a covered accident or sickness. You can custom design your plan to meet your needs

Cancer Insurance – Colonial

A little bit of preventative financial health.
A cancer diagnosis can change your life, and the expenses associated with a cancer diagnosis can be overwhelming. Cancer Insurance helps offset the out-of-pocket medical and indirect non-medical expenses related to cancer that most medical plans may not cover.

Policy Features

- Benefit payments are made directly to you
- Individual and family coverage available
- Pays benefits for annual cancer screening tests

Critical Illness – Colonial

Policy Features

- Pays you a lump sum benefit
- Annual health screening test benefit
- Offsets out-of-pocket medical and indirect non-medical expenses most medical plans don't cover
- Guarantee issue – no medical questions

Critical Illness Insurance is an insurance policy that will pay a lump sum payment if you experience an eligible critical illness, such as heart attack, permanent damage due to a stroke, major organ failure, or kidney failure

Accident Coverage – Colonial

Accidents can bring unexpected costs. An Accident Insurance plan may lessen the impact on your finances by paying benefits to help cover your expenses, regardless of any other coverage you have.

This product is inappropriate for people who are eligible for Medicaid coverage.

Policy Features

- Benefit payments are made directly to you
- Covers you on and off the job
- Individual and family coverage available
- Guarantee issue – no medical questions

Hospital Confinement – Colonial

Policy Features

- Pays you a lump sum benefit
- Offsets out-of-pocket medical and indirect non-medical expenses most medical plans don't cover

Provides a lump-sum benefit for hospital confinement and outpatient surgery to help offset the gaps caused by copayments and deductibles in most major medical plans.

Prudential Seminar Series*

A series of engaging financial wellness seminars delivered at your worksite by experienced financial professionals. These easy- to-understand seminars are designed to boost your confidence and the skills you need to pursue your financial goals.

Seminar 1

GREAT STRIDES: Understanding the Fundamentals of Financial Wellness

An introduction to financial wellness, including the benefits of living within a budget, the variety of savings and investing vehicles available, and some best practices to maximize savings.

Seminar 2

FOR THE LONG HAUL: Building Your Road to Retirement

Proven solutions for developing a retirement plan, creating a retirement income strategy, and avoiding roadblocks to financial security in retirement – whether retirement is right around the corner or in the distant future.

Seminar 3

CRUISING ALONG: Protecting Yourself and Your Loved Ones

Techniques to effectively protect the assets you've accumulated against a variety of circumstances, including a discussion of how insurance and employee benefits can work together to help maintain financial wellness.

Seminar 4

THE JOURNEY CONTINUES: Creating a Solid Plan for the Future

Planning for the future includes understanding the importance of compiling financial information and documents. Raise your awareness of the importance of estate planning concepts.

Learn about the importance of regular beneficiary reviews and asset consolidation. Gain an understanding of common wealth transfer strategies and estate planning pitfalls.

Executive Series Coming Soon:

Three 90 minute sessions on Advanced Asset Accumulation, Advanced Asset Distribution and Estate Planning Strategies.

*Can be offered in various formats

Annual Legal Notices

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

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 a 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.*

Creditable Coverage Disclosure Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Odessa R-VII 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. Odessa R-VII has determined that the prescription drug coverage offered by the Humana 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 District coverage may be affected. Your prescription drug benefit can be found in the Humana benefits summary and Certificate of Coverage.

If you do decide to join a Medicare drug plan and drop your current District coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the District 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. **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 the District 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 http://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 http://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).

Date:	May 14, 2017
Name of Entity/Sender:	Linda Eberhardt
Contact--Position/Office:	Bookkeeper
Address:	701 S. 3rd Street, Odessa, MO 64076
Phone Number:	816-633-5316

Special Enrollment Rights

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

In addition, if you acquire 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.

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

Women's Health and Cancer Rights Act

Did 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 reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? To request a copy of your summary plan description, please contact your human resources department (617) 449-0865 or a copy can be can be found under the document section in EMS.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**

Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Your Right to Receive a Notice of Privacy Practices

SAMPLE NOTICE OF PRIVACY PRACTICES TO BE USED BY HEALTH PLANS SUBJECT TO THE HIPAA PRIVACY RULES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication

- Ask us to limit the information we share
- 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 using the information on page 1.
- 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 disclose 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/index.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.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Notice Regarding Wellness Program

Odessa R-VII offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, blood pressure, glucose, and BMI. You can complete your biometric screening by seeing your personal physician or attending our annual onsite screenings offered every January. You are not required to complete the HRA or to complete a biometric screening. However, employees who choose not to complete both the biometric screening and HRA, will pay $20 per month in addition to their monthly medical premium. The $20 will be deducted beginning July 1 following the annual screening event.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as voluntary District sponsored wellness programs as well as voluntary programs available via your Humana member portal. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Odessa R-VII may use aggregate information it collects to design a program based on identified health risks in the workplace, Odessa R-VII will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are 1) the physician in your doctor's office that performs your screening or 2) the nurse that administers your screening should you participate in our onsite screenings.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Linda Eberhardt at Odessa R-VII.

Contacts for Questions

CBIZ Benefits & Insurance Services is our dedicated benefits broker/consultant, committed to providing you excellent service. CBIZ is available to answer benefit and problem claim questions when you are unable to obtain further information from the carrier, or when you feel the benefit determination was not paid according to our contract.

For General Information		Linda Eberhardt leberhardt@odessa.k12.mo.us 816-633-5316
For Benefit Questions		Maggie Releford Phone – 816-945-5242 mreleford@cbiz.com Jennifer Cross Phone - 816.945.5287 jcross@cbiz.com
Medical Insurance		www.humana.com 1-800-448-6262
Dental Insurance		www.deltadentalmo.com 1-800-335-8266
Vision Insurance		www.superiorvision.com 1-800-507-3800
Base & Voluntary Life		www.prudential.com
HSA		www.optumbank.com 1-866-234-8913
FSA		www.tri-starsystems.com (800) 727-0182
Income Protection Cancer Insurance Critical Illness Insurance Accident Only Insurance Hospital Confinement		Ryan Bowling Ryan.bowling@coloniallife-kc.com 1-800-325-4368

Request for Transition of Care

Thank you for allowing Humana to provide your health benefits. We appreciate your business and your trust.

Our records show that when your Humana coverage begins, you or a covered family member may be receiving care from a provider who is not in your plan's network. We understand that changing providers at this time may not be possible. To help promote the appropriate care, we have a "Transition of Care" exception process. This process helps us decide whether we can temporarily authorize care from an out-of-network provider while paying the charges at the in-network benefit level.

Conditions that may qualify for Transition of Care exceptions are pregnancies beyond 20 weeks, cancer therapy, post-operative periods, dialysis, planned non-elective procedures, home health therapy, and durable medical equipment (DME) services.

To request a Transition of Care exception, please complete the form below and mail or fax it to us as shown. We can only consider requests received **within 90 days of your effective enrollment date**. Our clinical staff will evaluate your request and notify you, in writing, of our decision, within 15 days after we receive this form. Also, we may need to call you to get more information before we make our decision.

Please note: We can't guarantee full payment of your expenses if your service is approved. Some costs may be excluded due to the limitations of your benefit plan.

Reasons you may have to pay a portion of these costs include:

- You have a deductible for your benefits you haven't met.
- Any copayments that you're responsible for under your plan benefits.
- Any portion of your healthcare expenses you're responsible for paying under your plan benefits once you've met your deductible. The percentage you pay is called coinsurance.
- If you exceed the maximum amount Humana will pay under your plan benefits.
- Any additional fees or expenses charged by a non-participating provider.
- Any amount over the Maximum Allowable Fee (MAF) charged by a non-participating provider.

Thank you for your patience while we review your request.

continued

Humana.

Request for Transition of Care

Please check the appropriate box for your request:

- ☐ Planned surgery or hospitalization after the effective date of your enrollment
- ☐ Home health care services you are currently receiving
- ☐ Durable medical equipment you are currently using
- ☐ Ongoing medical treatment, such as chemotherapy, dialysis, radiation, hospitalization, etc.
- ☐ Pregnancy Expected Due Date: _____/_____/_____ (MM/DD/YY)
- ☐ Other condition or additional comments:
  (please be specific, and include the subscriber's name, ID, and patient's name on any additional pages you send)

_____

_____

This does not include pharmacy-related services like medications or prescriptions.

Subscriber's Full Name: (first/middle/last)		Birth Date: (mm/dd/yy) / /
Patient's Full Name: (first/middle/last)		Birth Date: (mm/dd/yy) / /
Address:		
City:	State:	Zip:
Home Phone: ( )		Work/Cell Phone: ( )
Effective Date of Enrollment: (mm/dd/yy)		Employer/Group Name:
Member ID Number of Subscriber or Social Security Number:		
Physician: Name/Phone Number of Primary Care Physician:		
Name/Phone Number of Doctor Handling Treatment:		
Treating Doctor's Specialty:		

Please mail this completed form to:

Clinical Intake Team
Humana Inc.
PO Box 400029
San Antonio, Texas 78229

Or fax form to: 1-800-266-3022

Humana.

Odessa R-VII
2017Benefits Enrollment Worksheet

In order to expedite your enrollment, it is recommended that you complete this worksheet. Any missing information could slow down your enrollment experience.

Legal Name	SSN	Relationship	Gender	Date of Birth	Medical Yes / No	Dental Yes/No	Vision Yes/No

MEDICAL – HUMANA			
	QHDHP	BASE PPO	BUY-UP PPO
Employee Only	❑ $0	❑ $0	❑ $55.03
Employee + Spouse	❑ $497.20	❑ $588.71	❑ $698.78
Employee + Child(ren)	❑ $522.06	❑ $618.15	❑ $730.97
Family	❑ $904.91	❑ $1,071.46	❑ $1,226.65

DENTAL – DELTA DENTAL OF MO:		
Employee Only	❑ $35.29	❑ $44.03
Employee + Spouse	❑ $69.11	❑ $86.24
Employee + Child(ren)	❑ $99.90	❑ $124.52
Family	❑ $133.57	❑ $166.68
Waive	❑	

VISION – SUPERIOR	
Employee Only	❑ $8.93
Employee + Spouse	❑ $15.17
Family	❑ $25.19
Waive	❑

HSA - Optum:
Only available with the QHDHP plan. Not available if you or your spouse are contributing to a FSA.

- If you want to contribute to the Healthcare Account, you may elect to have your contributions deducted on a pre-tax basis. Do you want to participate?

  ☐ Yes – Employee Contribution Amount $_____/paycheck (2017 tax year limits $3,400/individual or $6,750/family). This is the combination of any employer + employee contributions). This election amount can be changed as often as monthly if desired – you must change in accounting/payroll.

  The District will contribute $91.50 per month ($1,098 annually) for the 2017-2018 plan year.

  ☐ No

Flexible Spending Account (FSA)- Tri-Star

Remember: 1) Not available if you or your spouse participates in a HSA.
2) You must use the entire amount that you elect or the remaining funds will be forfeited.

- If you want to contribute to the Flexible Spending Account, you may elect to have your contributions deducted on a pre-tax basis. Do you want to participate?

  ☐ Yes – Plan Year Contribution Amount $_____ ($2,550 plan year max.)
  ☐ No

Dependent Care Spending Account – Tri-Star:

Remember: 1) Available with or without a HSA
2) You must use the entire amount that you elect or the remaining funds will be forfeited.

- If you want to contribute to the Dependent Care Spending Account, you may elect to have your contributions deducted on a pre-tax basis. Do you want to participate?

  ☐ Yes - Plan Year Contribution Amount $_____($5,000 plan year max.)
  ☐ No

Basic Life and AD&D – Prudential: This is a District paid benefit. Please list your beneficiary below.

Beneficiary Name	Relationship	Social Security Number	Date of Birth	Primary or Contingent	Percent (must add up to 100%)	Trust or Individual

Voluntary Life and AD&D – Prudential: (You will need to request an Evidence of Insurability form from Linda Eberhardt)

	Amount Newly Elected
Employee	$
Spouse	$
Child(ren)	$

Are you interested in participating in the Prudential Pathways Financial Seminars referenced on page 19?

☐ Yes ☐ No

How to make mid-year changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.