Bonner Springs / Edwardsville USD 204

2017 Retiree Benefits Enrollment Guide

2017 Annual Benefit Enrollment News

July 1, 2017 marks the renewal of your retiree benefit plans. Due to favorable plan utilization, we were able to secure an 18 month medical renewal. What this means to you:

1) The District's medical plans and rates will be locked in for 18 months beginning July 1, 2017 through December 31, 2018.

2) There is only one plan change that applies to the HMO only. As of July 1, 2017, chiropractic care will have a $40 copay for each date of service.

3) We will hold open enrollment this spring with an effective date of July 1, 2017 – December 31, 2017

4) We will hold a second open enrollment this fall with an effective date of January 1, 2018 – December 31, 2018. You can choose to make plan changes at that time if you wish, or keep your elections the same.

How to Enroll, Waive, and Confirm Benefits

Our July 1, 2017 open enrollment will begin May 1st and run through May 12th. Everyone must complete the enrollment worksheet at the back of this guide in order to maintain your current benefits, or make a change. Your enrollment worksheet needs to be returned to Stormi Vitt in the District office no later than May 12th. Failure to complete your enrollment by the deadline will result in no coverage.

Benefits/Enrollment Communications

The District has moved the enrollment communications to an electronic format that allows you to view your benefits/enrollment information via your computer or mobile device. This technology also allows you to click on links to carrier websites and videos providing additional helpful tools and resources.

As a retiree, we currently provide your communications via mail. If you would like to receive your benefits/enrollment communication electronically in the future, please provide your email address at the bottom of the enrollment worksheet at the end of this guide.

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 as a Blue Cross Participant

Medical Insurance video links for better consumerism:

- Onboarding to A-Healthier-You Portal
- Building A-Healthier-You Care Plan
- How the General Health in A-Healthier-You Plan Works
- Rx Savings Solutions

Retail Telehealth

Blue Cross and Blue Shield of Kansas City (Blue KC) wants to improve your access to care. That's why we've partnered with American Well (Amwell) to bring you care from the comfort and convenience of your home or wherever you are. Schedule and "see" a doctor online from your phone, tablet or computer, from home, the office or while traveling using the Amwell mobile app. Signing up is free, just download the app or visit Amwell.com. Download the iOS or Android App by searching "Amwell". Sign up on the web at Amwell.com. Be sure to include your Blue KC Insurance information when creating your account. For detailed instructions, see Amwell – A Quick Guide.

amwell

CONDITIONS COMMONLY TREATED THROUGH A VIRTUAL VISIT:

- Colds
- Flu
- Migraines
- Sinusitis
- Fever
- Rash
- Pinkeye
- Ear Infection
- Abdominal Pain

Discover Your A Healthier You™ Portal

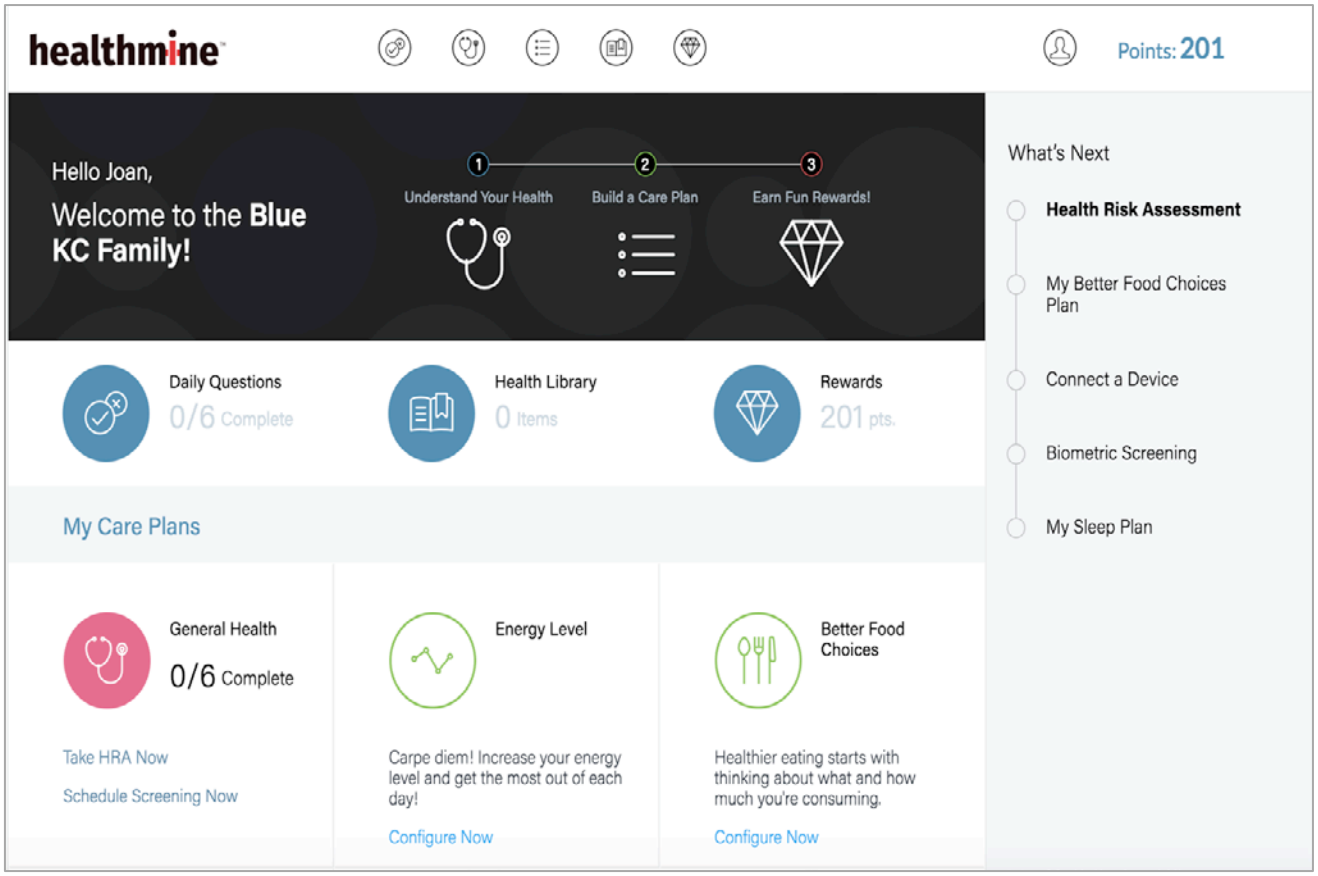
With just a few clicks, you can easily access your personalized health and wellness portal.

1. Visit MyBlueKC.com or download the Blue KC A Healthier You App.
   *Use Google Chrome browser.

2. Enter your username and password, and click **LOG IN**. If you are a first time visitor, click **REGISTER NOW.** Be sure to have your member ID card available to reference.

3. Once logged in, click on **A Healthier You** from the "My Home" page.

4. First time users will be prompted to complete the onboarding personalization questions.



Kansas City | a healthier you

Doctor and Hospital Finder

FIND A DOCTOR OR HOSPITAL, PLUS BLUE DISTINCTION TOTAL CARE DOCTORS

LOG INTO MYBLUEKC.COM

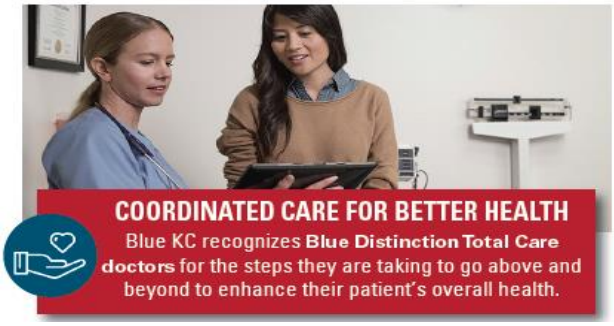
To view the most accurate information related to your Blue KC network, be sure to **first log in** as a member on MyBlueKC.com.

1. **Log in or register**
   (if this is your first time logging in, you will need your Blue KC member ID card to reference.)
2. **After logging in**, you will see the same menu screen at the top. Click "Find a Doctor."

NARROW SEARCH RESULTS

After you run a search you will see the following:

1. Match Listing - See how many results your search produced based on your search criteria.
2. Search Results - See the providers that matched your search criteria, plus a link to view their profile.
3. Filters to Find Total Care Providers - Use search filters to narrow results based on provider **gender**, **distance**, **specialty**, **languages spoken** and **quality recognitions** including the **filter "BDTC" to find a Blue Distinction Total Care doctor**.
4. Sort - Sort the results based on the search criteria (default), distance, or alphabetically.
5. Save and Print - Create a customized directory based on your search and save as a PDF, email or print it.

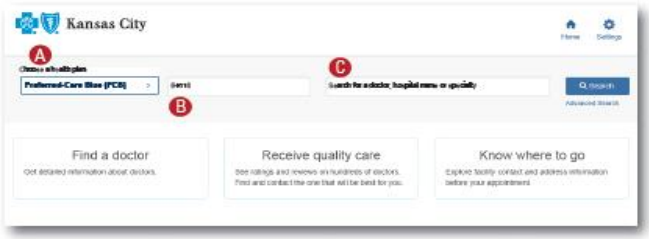


START YOUR SEARCH

A. Choose your health plan – If you logged in, your plan's network should already display. If it does not, see your Blue KC member ID card; your network appears on the top of the ID.

B. Location – Select the location that you would like to search (city, ZIP code, etc.). The radius default is 25 miles; you can adjust to as low as one mile on the search results page.

C. Search by – You can search a variety of ways; simply enter a doctor or hospital name, a health condition, or even a specialist type that treats a health condition.



PROVIDER REVIEWS

Easily read and write provider reviews and rate your care on a scale of one to five stars. Your feedback helps doctors and staff make improvements, plus, by rating your doctor, you will help others locate physicians with high patient satisfaction scores. Surveys are confidential – doctors will not know you rated them.

COST INFORMATION

The Blue KC cost forecaster uses 12 months of claims data to provide a cost range for over 1,000 of the most common, elective procedures. *For example, the total cost for a knee replacement at a specific hospital may be $19,000 to $23,000.*

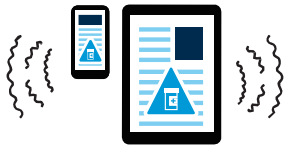
The cost forecaster tool can be found on the **Get Care** page of MyBlueKC.com, then click **What I Need to Pay**.

Rx Savings Solutions

Rx Savings Solutions was created by a pharmacist who found ways to help consumers save money. Prescription prices can vary widely, even within the same ZIP code. This is a new way to save on prescription medications by bringing cutting-edge technology that will notify you when you and your family can save at the pharmacy.

STEP 1

GET SAVINGS ALERTS

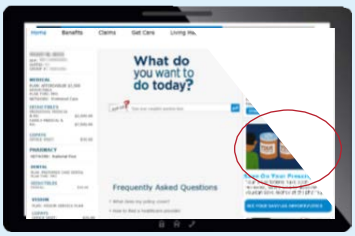


Set-up alerts via text and/or email

A Visit MyBlueKC.com.

B If you are a first time visitor, click **REGISTER NOW**. Please have your member ID card available to reference.

C Once logged in, click on the **Pharmacy Savings** image.



D Fill in your **email address** and **mobile phone number**.

Start receiving email and/or text alerts from Rx Savings Solutions!

STEP 2

REVIEW YOUR SAVINGS OPTIONS AND SHARE WITH YOUR DOCTOR

Example: Switch from Pharmacy A to Pharmacy B.

Example: Switch to a different, equally-effective medication.*

STEP 3

START SAVING ON PRESCRIPTIONS

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.bluekc.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.bluekc.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 Provider Networks

Bonner Springs/Edwardsville USD 204 currently offers five medical plans and three provider networks for you to choose from. It is *very important* that you understand your network of providers when choosing the plan that is right for you.

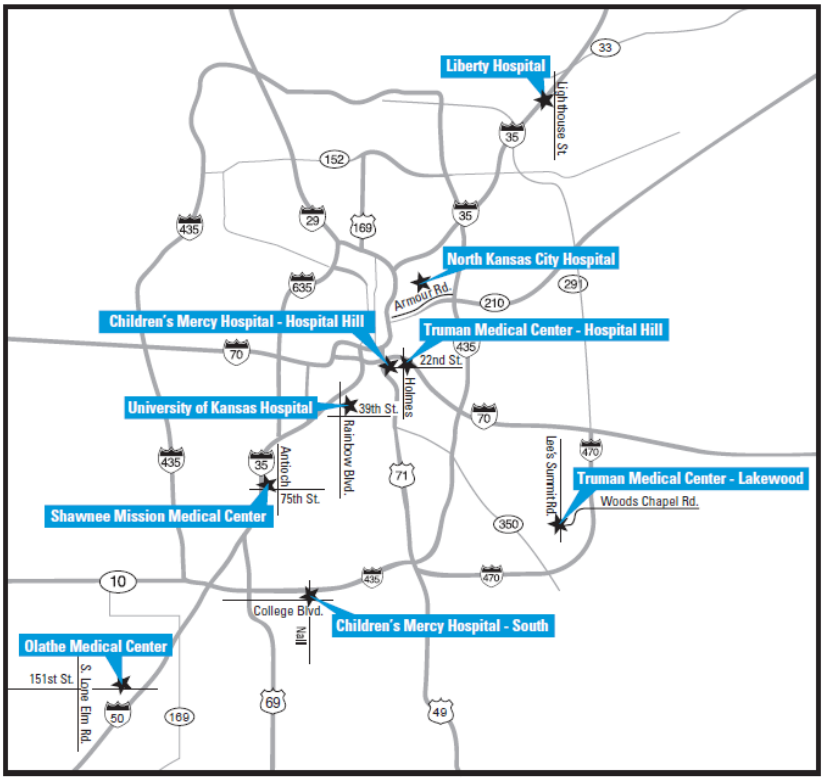
	Networks				
	QHDHP #1	QHDHP #2	BASE PPO	BUY-UP PPO	HMO
Preferred-Care Blue	X		X	X	
Blue Select Plus		X			
Blue Care					X

Network Differences		
Preferred-Care Blue	**Blue Care HMO**	**Blue Select Plus**
1) Applies to : QHDHP #1 Base PPO Buy-Up PPO	1) Applies to: HMO	1) Applies to: QHDHP #2
2) Larger network in Greater KC area as well as Nationally and Internationally	2) Hospitals and Providers are limited to Greater KC area only.	2) Smallest network, limited to 7 hospitals and approximately 2900 providers
3) Provides out-of-network coverage	3) No coverage out-of-network unless it is an emergency	3) Providers in the Greater KC area, but not participating in the Blue Select Plus Network, are subject to the out-of-network deductible and out-of-pocket maximum If you are outside of the Greater KC area and need care, you will have access to the BCBS national Blue Care PPO network and receive in-network benefits

The Blue Select Plus network has a more limited network of providers and hospitals. Because it is a more exclusive network of providers, BCBS is able to provide better discounts when claims are incurred and therefore, your monthly premium is lower.

It is imperative that you review the providers and hospitals in the Blue Select Plus network before selecting to enroll in the QHDHP #2. While the plan works just like the QHDHP #1, if you elect the Blue Select Plus QHDHP #2 and use a provider or hospital **outside** the Blue Select Plus network, **your out-of-pocket maximum will increase to $13,000 individual or $26,000 family.**

The Blue Select Plus network of hospitals is limited to the following hospitals. Any other hospital used in a non-emergent situation will be considered out-of-network and subject to the out-of-pocket maximums previously mentioned.



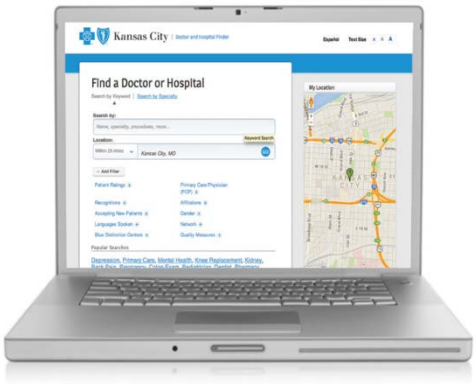
Blue Select Plus Hospitals are limited to:

Children's Mercy Hospital
Liberty Hospital
North Kansas City Hospital
Olathe Medical Center
Shawnee Mission Medical Center
Truman Medical Center
University of Kansas Hospital

All other hospitals in BCBS's service area are considered out of the Blue Select Plus network

Members have choices in physicians and other healthcare providers. You can search online for physicians and other healthcare providers by visiting the Blue KC website at www.bluekc.com, clicking **Find a Doctor**. From here you can

- *Choose* **Blue Select Plus** as the network and hit go (be sure your location information is listed correctly first) or,
- You can scroll to the bottom of the page and click View Our PDF/Print Directory. On the next screen you will want to select the **Blue Select Plus Quick Reference Directory** to review in network provider options.



Medical Plan

Bonner Springs/Edwardsville USD 204 is pleased to announce that we have secured an 18 month renewal with no increase beginning July 1, 2017 through December 31, 2018. There is only one plan change that applies to the HMO only. As is noted in the chart below, as of July 1, 2017, chiropractic care on the HMO will have a copay for each date of service. We appreciate everyone's efforts continuing to help to keep our healthcare costs down.

When reviewing your plan options, please be sure to pay close attention to the provider network associated with each plan.

Kansas City

Through www.bluekc.com you will have the ability to:

- Find Doctors & Hospitals
- Check Claim Status
- Order New ID Card
- Print Temporary ID Card
- View Benefits
- Access BCBSKC Drug List

	QHDHP #1	QHDHP #2	Base PPO	HMO	Buy-Up PPO
	Preferred Care Blue	**Blue Select Plus**	**Preferred-Care Blue**	**Blue Care**	**Preferred-Care Blue**
Deductible **- Individual** **- Family**	 $2,600 $5,200	 $2,600 $5,200	 $1,000 $2,000	 None None	 $500 $1,000
Coinsurance	0%	0%	20%	0%	20%
Out of Pocket Max **- Individual** **- Family**	 $2,600 $5,200	 $2,600 $5,200	 $4,000 $8,000	 $3,000 $7,500	 $2,750 $5,500
Physician Office Visits **- PCP** **- Specialist** **-Chiropractic**	 Subject to Ded. Subject to Ded. Subject to Ded.	 Subject to Ded. Subject to Ded. Subject to Ded.	 $40 $80 Ded. then 20%	 $40 $80 $40 **(New)**	 $20 $40 Ded. then 20%
Hospital Services **- Inpatient** **- Outpatient surgical** **- Hi-Tech Scans**	 Subject to Ded. Subject to Ded. Subject to Ded.	 Subject to Ded. Subject to Ded. Subject to Ded.	 Ded. then 20% Ded. then 20% Ded. then 20%	 $500 per day up to $2,500/ calendar year/person	 Ded. then 20% Ded. then 20% Ded. then 20%
Emergency Room **Urgent Care**	Subject to Ded. Subject to Ded.	Subject to Ded. Subject to Ded.	$200 then Ded. then 20% $80	$200 $80	150 then Ded. then 20% $40
Prescription Drugs **- Deductible** **- Tier 1 Generic** **- Tier 2 Preferred** **- Tier 3 Non-Preferred** **- Mail order (120 day)**	 Medical Ded. then: $0 $0 $0 $0	 Medical Ded. then: $0 $0 $0 $0	 N/A $12 $35 $60 $24/$70/$120	 N/A $12 $35 $60 $24/$70/$120	 N/A $12 $35 $60 $24/$70/$120

This Medical Plan table 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 certificate of coverage BCBS 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 retiree costs for each plan per month.

	RETIREE ONLY	RETIREE + FAMILY
QHDHP #1	$454.10	$1,139.75
QHDHP #2	$399.61	$1,002.98
BASE PPO	$468.19	$1,173.96
HMO	$502.89	$1,260.96
BUY-UP PPO	$553.80	$1,390.00

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 BCBS 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 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):

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, both QHDHPs, will have a $2,600 Individual/$5,200 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. Retirees, 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.

(Note: There is a $2.00 monthly account fee automatically deducted from your HSA.)

What are some of the advantages of a HSA?

What is an HSA

Less monthly premium paid on a QHDHP allows for discretionary 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, Retiree 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

Dental Plan

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

The Delta Dental of Kansas Premier Network is a large network of dentists. You may access website information by going to Delta Dental of Kansas Insurance, or call them at 1-800-234-3375. 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

	Premier Network
Deductible	
- Individual - Family - Waived for Preventive	$50 $150 Yes
Coinsurance	
- Preventive - Basic - Major	100% 80% 50%
Maximum Benefits - Calendar year Maximum	$1,000

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

	Retiree Cost Per Month
Retiree Only	$30.57
Retiree + Spouse	$60.51
Retiree + Child(ren)	$60.80
Retiree + Family	$102.94

Vision Plan

The vision benefits will continue to be offered through Surency. While there are no changes to the current benefits offered, there is a minimal increase to the rates.

To identify participating providers, you may go to www.surency.com or call 1-866-818-8805.

Vision Insurance video for better consumerism:

Why Eye Exams are important for Your Vision Health

SURENCY	
Copays	
- Exams - Lenses (Single, Bifocal, Trifocal)	$10 $25
Frequency Limitations	
- Exams - Lenses - Frames	Once every 12 months Once every 12 months Once every 24 months
Reimbursement Schedule	
- Exam - Glass Lenses - Single - Bifocal - Trifocal - Contact Lenses - Frames	100% 100% 100% 100% $115 allowance, 15% off amount of $115 $100 allowance

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

	Retiree Cost Per Month
Retiree Only	$7.76
Retiree + Spouse	$16.27
Retiree + Child(ren)	$13.95
Retiree + Family	$26.10

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 Bonner Springs/Edwardsville USD 204 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. Bonner Springs/Edwardsville USD 204 has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Kansas City 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 BCBS 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:	April 17, 2017
Name of Entity/Sender:	Stormi Vitt
Contact–Position/Office:	HR Coordinator
Address:	2200 S. 138th St., Box 435, Bonner Springs, KS 66012
Phone Number:	913-422-5600 ext. 1010

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

Bonner Springs/Edwardsville USD 204 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 BlueKC 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 Bonner Springs/Edwardsville USD 204 may use aggregate information it collects to design a program based on identified health risks in the workplace, Bonner Springs/Edwardsville USD 204 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 Eric Hansen at Bonner Springs/Edwardsville USD 204.

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	**Stormi Vitt** HR Coordinator vitts@usd204.net 913-422-5600 Ext. 1010
CBIZ	For Benefit Questions	**Maggie Releford** Phone – 816-945-5242 mreleford@cbiz.com **Jennifer Cross** Phone - 816.945.5287 jcross@cbiz.com
Kansas City LIVE FEARLESS	Medical Insurance	www.bluekc.com 816-395-2270
DELTA DENTAL	Dental Insurance	www.deltadentalks.com 1-800-234-3375
Surency VISION	Vision Insurance	www.surency.com 1-866-818-8805

Bonner Springs/Edwardsville USD 204
2017 Retiree Benefits Enrollment Worksheet

This form must be returned to Stormi Vitt in the District office no later than May 12, 2017.

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

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MEDICAL – BCBS OF KC					
	QHDHP #1	QHDHP #2	BASE PPO	HMO	BUY-UP PPO
Retiree Only	❑ $454.10	❑ $399.61	❑ $468.19	❑ $502.89	❑ $553.80
Family	❑ $1,139.75	❑ $1,002.98	❑ $1,173.96	❑ $1,260.96	❑ $1,390.00
Waive	❑				

DENTAL – DELTA DENTAL OF KS:	
Retiree Only	❑ $30.57
Retiree + Spouse	❑ $60.51
Retiree + Child(ren)	❑ $60.80
Family	❑ $102.94
Waive	❑

VISION - SURENCY	
Retiree Only	❑ $7.76
Retiree + Spouse	❑ $16.27
Retiree + Child(ren)	❑ $13.95
Family	❑ $26.10
Waive	❑

Would you like to receive future benefits and enrollment communication electronically?

☐ Yes. Please provide your email address: _____
☐ No