Tonganoxie USD #464

ENROLLMENT GUIDE

Effective October 1, 2017

Welcome!!

Welcome to Tonganoxie USD #464. The benefits outlined in this guide are effective October 1, 2017. Please take the time to review the information and ask any questions you may have. We feel it is very important that you have a strong understanding of your benefits. If at any time throughout the course of the year you should have questions about how your plans work, or if you need clarification or assistance with a claim issue, please feel free to reach out to our CBIZ consultants listed on page 27. They are always happy to assist.

How to Enroll, Waive, and Confirm Benefits

Enrollment will begin August 21st and run through August 30th. Everyone must complete the online enrollment process during this time. Failure to complete your online enrollment by August 30th will result in no coverage.

Assisted Enrollment: Provides you the opportunity to sit down one-on-one with an enroller to complete your benefits enrollment. The enroller will be able to answer any outstanding questions you may have at this time. Assisted 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.
Please use the buttons below to schedule your enrollment session.

August 28, 2017
TES Conference Room

August 29, 2017
TMS Conference Room

August 30, 2017
THS Conference Room

Enrollment Meeting

CBIZ will hold a benefit orientation meeting to review the benefits available to you on August 9, 2017.

Who is Eligible?

If you are a full-time employee (working 20 or more hours per week) you are eligible to enroll in the benefits described in this guide. Your spouse and legally dependent children to age 26 are also eligible for medical, dental and vision coverage.

How to make 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.

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.

Resources Available as an Aetna Plan Participant

Medical Insurance video links for better consumerism:

Teledoc Mobile App Demo

Member Payment Estimator

Compare costs for over 650 medical tests, services and procedures at up to 10 doctors/facilities/hospitals at once. The Member Payment Estimator tells you where in your area — and in our network — you can find these services. Estimates are based on your own plan details, such as your deductible and coinsurance. So they're personalized.

Click here to Register or login to use the tool

Estimate the Cost of Care

Get average network and out-of-network costs for tests (X-rays and MRIs), office visits (including specialists), selected surgeries and procedures (such as colonoscopy, sinus surgery), routine physicals, and emergency room visits. If you have a chronic condition, such as asthma, diabetes or high blood pressure, you can find out the yearly costs, on average, associated with your condition.

Click here to Register or login to use the tool

Money^{2} $_{SM}$ for Health

Paying your health care bills should be as easy as paying your other bills. Now it is with Money^{2}for Health.

- Link your checking account, credit card and most health savings accounts and flexible spending accounts to your Money^{2} for Health account.
- Get alerts when a claim indicates you have a bill.
- Pay doctors, specialists or hospitals online from one place – your secure member website.

iTriage

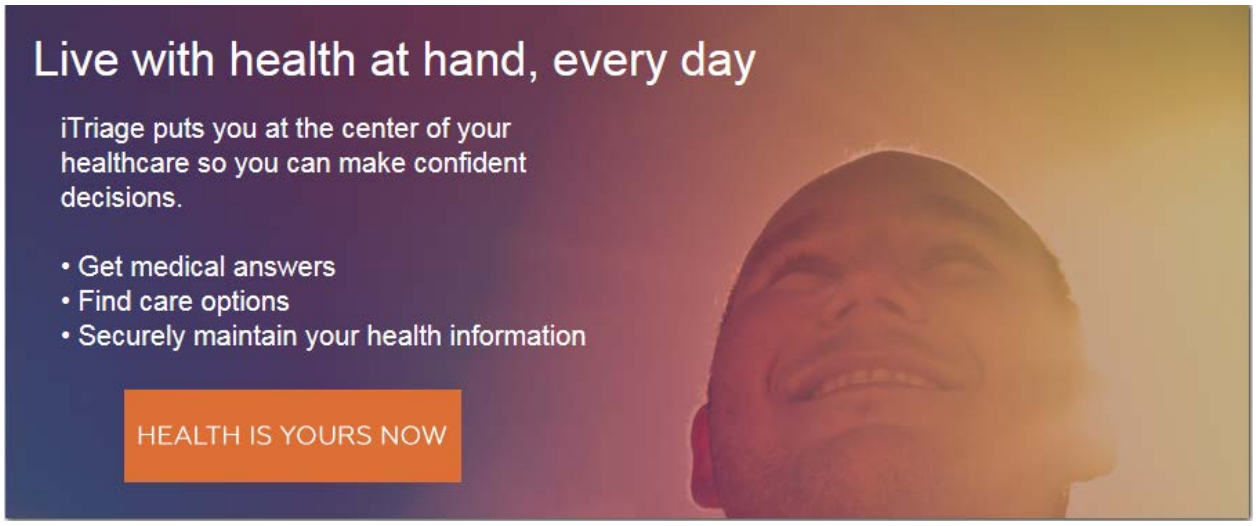
iTriage connects patients, providers and health plans through technology to deliver personalized data insights that empower people to take action on their healthcare. They also partners with hospitals and health systems, accountable care organizations, retail clinics, health plans, and employers to improve population health.

Use iTriage to safely store information on doctors, medications, insurance, conditions and procedures.

<u>iTirage can help you:</u>

- Manage your conditions – all of your information is in one place so you can easily share it with doctors, pharmacist, and family member; anytime and anywhere.
- Track your appointments – save and manage appointments you've book through iTriage or on your own

[Please click here to visit the site]



[Click here to take a tour of My iTriage]

made available through aetna®

TELADOC.

Talk to a  anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for $40 or less

Pay only your doctor visit copay (or deductible) for a Teladoc consult!

10 Min	24/7	92%	95%
average response time	anytime, anywhere	of patient issues resolved after first visit	member satisfaction

Please visit teladoc.com/aetna for further information

Pharmacy Solutions

Aetna offers Pharmacy Online Tools and Services that provides tools for drug savings and smart decisions.

These are the tools that can help you:

- Find plan details – like your copays and what's covered
- Compare drug costs
- Get medicine mailed straight to your door

Services that can help you save on drug costs:

Your mail order pharmacy:

You may take medicine every day for a contiion like ashtam or diabetes. With Aetna Rx Home Delievy, your medicine is sent right to your mailbox, or anywehere you choose – with free standard shipping. You can get up to a 90-day supply. And you may pay less, depending on your plan.

Your specality pharmacy:

Maybe you take medicine for complex condiiont like multipls scerecosis or anemia. Aetna Speciality Pharmacy will fill these drugs and handle them with care.

Your medicine is sent straight to your mail box or anywhere you choose – with free, secure shipping. And you can take advantage of extra help – like trianing on how to self-inject your medicine or cope with side effects or other issues.

Make smart decisions and save. Use www.aetnapharmacy.com and secure your member website.

aetna®

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.aetna.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.aetna.com -- Should you go to Urgent Care or ER?

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

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
- 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

Tonganoxie UDS#464 offers three medical plan options for you to choose from. The benefits you elect now will be effective October, 2017 – September 30, 2018.

We recommended that you visit www.aetna.com or call 1-800-238-6716 to see if your provider is in the Aetna Network.

The Medical Plan chart below 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 Aetna summary for greater detail. In the event there is a discrepancy in benefits, the carrier benefit summary/SPD will always govern.

aetna®

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

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

	QHDHP	BASE PPO	BUY-UP PPO
Deductible - Individual - Family	 $2,700 $5,400	 $2,000 $4,000	 $1,500 $3,000
Coinsurance	0%	50%	30%
Out of Pocket (OOP) Max - Individual - Family	$3,500 $7,000	$5,000 $10,000	$6,000 $12,000
Physician Office Visits - PCP - Specialist	 Subject to Ded. Subject to Ded.	 $40 $40	 $25 $50
Hospital Services - Inpatient - Outpatient surgical	 Subject to Ded. Subject to Ded.	 Ded. then 50% Ded. then 50%	 Ded. then 30% Ded. then 30%
Emergency Room	Subject to Ded.	Deductible then $200 copay	Deductible then $200 copay
Urgent Care	Subject to Ded.	$50	$50
Prescription Drugs - Deductible	 Deductible then copays	 N/A	 N/A
- Tier 1A - Tier 1 - Tier 2 - Tier 3 - Tier 4 Preferred Non-Preferred	$3 $12 $50 $75 20% up to $150 20% up to $250	$3 $12 $40 $65 20% up to $150 20% up to $250	$3 $12 $40 $65 20% up to $150 20% up to $250

Medical Plan Cost

Below are the monthly rates for each plan. These do not reflect any district contribution.

	QHDHP	BASE POS	BUY-UP POS
Employee Only	$530.02	$557.18	$570.95
Employee + Spouse	$1,171.88	$1,232.60	$1,260.31
Employee + Child(ren)	$848.35	$892.16	$912.83
Family	$1,375.38	$1,446.75	$1,478.86

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 Aetna 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): Mutual Savings Bank

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 $2,700 Individual/$5,400 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, and prescriptions become subject to your rx copays.

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. The 2018 maximum is $3,450 individual, $6,900 family. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

What are some of the advantages of a HSA?

What is an HSA?

Less monthly premium paid on a QHDHP allows for discretionary employee 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 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 FSA is $2,500. All the funds are available day one of the plan year.

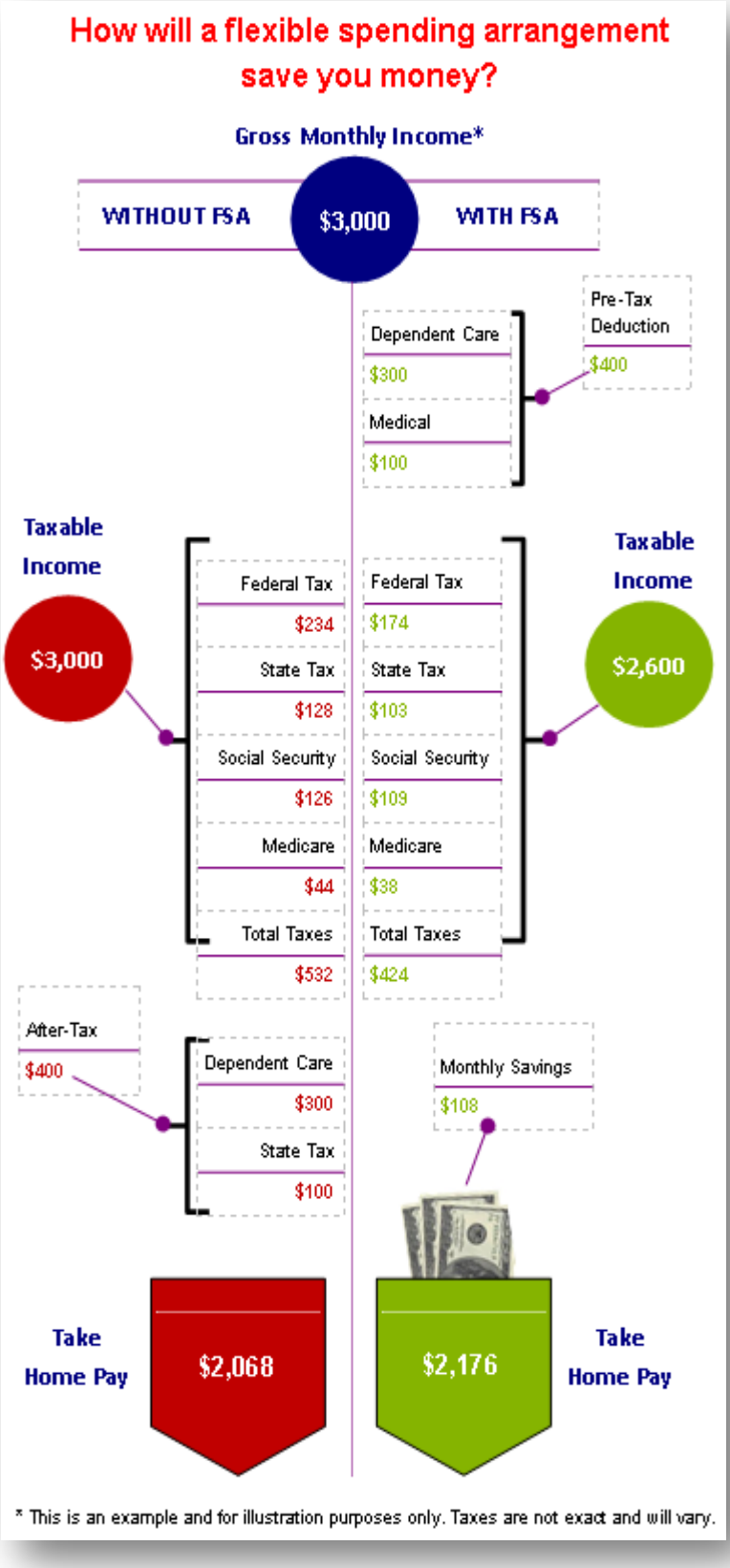
Part 3) Dependent Daycare Account

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 Kansas.

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.

	Base	Buy-Up
Deductible		
- Individual - Family - Waived for Preventive	$50 $150 Yes	$50 $150 Yes
Coinsurance		
- Preventive - Basic - Major - Ortho	100% 80% 50% Not Covered	100% 80% 50% 50%
Maximum Benefits - Calendar year Maximum - Orthodontic Maximum	 $1,000 N/A	 $1,000 $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

	Base	Buy-Up
Employee Only	$31.51	$35.29
Employee + Spouse	$63.02	$70.59
Employee + Child(ren)	$50.42	$56.46
Employee + Family	$108.05	$121.02

Vision Plan

The vision benefits will continue to be offered through Superior Vision. To identify participating providers, you may go to www.superiorvision.com, or call 1-800-507-3800.

Vision Insurance videos for better consumerism:

Why Superior Vision

Member Portal Webinar

Find an In-Network Provider

What makes us Superior

	Materials Only	Full Benefit
Copays		
- Exams - Lenses (Single, Bifocal, Trifocal) - Contact Lens Fitting	Not Covered $15 $15	$15 $15 $15
Frequency Limitations		
- Exams - Lenses - Frames	Not Covered Once every 12 months Once every 24 months	Once every 12 months Once every 12 months Once every 24 months
Reimbursement Schedule		
- Exam - Glass Lenses - Single - Bifocal - Trifocal - Progressive - Lenticular - Contact Lenses - Non-elective - Elective - Frames	Not Covered Covered in full Covered in full Covered in full Covered at lined trifocal level Covered in full Covered in full $120 allowance $125 allowance	Covered in full Covered in full Covered in full Covered in full Covered at lined trifocal level Covered in full Covered in full $120 allowance $125 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

	Materials Only	Full Benefit
Employee Only	$6.47	$8.41
Employee + Spouse	$12.80	$16.66
Employee + Child(ren)	$12.56	$16.31
Employee + Family	$19.10	$24.81

Basic Life/AD&D Plan - Metlife

Tonganoxie USD #464 provides a basic $20,000 term life insurance benefit at no cost to you. Additionally, you will receive Accidental Death and Dismemberment (AD&D) coverage in the amount of $20,000. Please be sure your beneficiary information is up to date for all life insurance coverage.

Voluntary Life Plan - Metlife

Employees who want to supplement their District paid basic life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. You can purchase coverage as follows:

Employee: You may purchase coverage in units of $10,000 to 5x salary and a maximum of $500,000. During your initial new hire enrollment, you may purchase up to $200,000 coverage without proof of good health/evidence of insurability. If you waive coverage at your initial enrollment all future increases will be subject to Evidence of Insurability. You can find the Evidence of Insurability form on the HR website, or request an Evidence of Insurability form from Audra Boone.

Spouse: You may purchase coverage for your eligible spouse in increments of $5,000 to a maximum of $100,000, not to exceed 50% of your employee election. You must be enrolled if you add life coverage for your spouse. During your initial new hire enrollment, you may purchase up to $30,000 coverage for your spouse without proof of good health/evidence of insurability. Any amount in excess of $30,000 will require Evidence of Insurability. You can find the Evidence of Insurability form on the HR website, or request an Evidence of Insurability form from Audra Boone.

Children: You may purchase coverage for your eligible children between the ages of 1 and 25 in the amount of $10,000 for $2.00 per month. The full amount is guarantee issue without evidence of insurability.

Age	Employee & Spouse Rates per $1,000
< 25	$0.065
25 – 29	$0.065
30 – 34	$0.075
35 – 39	$0.105
40 – 44	$0.165
45 – 49	$0.225
50 – 54	$0.435
55 – 59	$0.655
60 – 64	$0.675
65 – 69	$1.195
70 +	$2.765

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.

Annual Legal Notices

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 Tonganoxie USD #464 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. Tonganoxie USD #464 has determined that the prescription drug coverage offered by the Aetna 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 Aetna 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:	August 9, 2017
Name of Entity/Sender:	Audra Boone
Contact--Position/Office:	Clerk
Address:	330 East Highway 24-40 Tonganoxie KS 66086
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)? Contact Audra Boone (913) 416-1400 or aboone@tong464.com for more information.

HIPPA Privacy Notice – Notice of Privacy Practices

Notice of Privacy Practices

The Tonganoxie USD #464 Health and Welfare Plan ("Plan") has the duty to protect your medical information. The Plan further has the duty to provide you with a notice of its privacy practices, which follows. The Plan has the right to change or modify this notice, at any time, and any modifications will be communicated to you. This notice describes how your medical information may be used and disclosed, and how you can get access to it. Please review it carefully.

The Health Insurance Portability and Accountability Act limits how a covered entity can use and disclose protected health information (PHI). Generally, a covered entity, including your health plan, your health care provider, or, a health care clearinghouse, can share information without your authorization, for purposes of treatment of you, payment for your medical

services, and for the health plan's operation. In all other instances, you must authorize any disclosure of your health information.

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.

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.

Notice Regarding Wellness Program

Tonganoxie USD #464 Wellbeing program is 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. You are not required to complete the HRA or to participate in the biometric screening or other medical examinations.

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 Tonganoxie R-VII may use aggregate information it collects to design a program based on identified health risks in the workplace, Tonganoxie R-VII Wellbeing program 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 is (are) those such as "a registered nurse," "a doctor," or "a health coach" in order to provide you with services under the wellness program.

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 aboone@tong464.org or 913-416-1400, ext 1002.

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	Tonganoxie USD 464	Audra Boone aboone@tong464.org 913-416-1400 ext. 1002
For Benefit Questions	CBIZ	Maggie Releford Phone – 816-945-5242 mreleford@cbiz.com Sarah Kane Phone – 816-945-5545 skane@cbiz.com
Medical Insurance	aetna®	www.aetna.com 1-800-238-6716
Dental Insurance	DELTA DENTAL®	www.deltadentalks.com 1-800-234-3375
Vision Insurance	SUPERIOR VISION See yourself healthy.	www.superiorvision.com 1-800-507-3800
Base & Voluntary Life	MetLife	www.prudential.com
HSA	Mutual SAVINGS BANK	Jennifer Gumbel JenniferG@MutualMail.com 913-845-2556
FSA	CBIZ	www.myplans.cbiz.com (800) 815-3023
Income Protection Cancer Insurance Critical Illness Insurance Accident Only Insurance Hospital Confinement	Colonial Life Making benefits count.	Ryan Bowling Ryan.bowling@coloniallife-kc.com 1-800-325-4368

Tonganoxie USD#464
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 – AETNA			
	QHDHP	BASE PPO	BUY-UP PPO
Employee Only	❑ $530.02	❑ $557.18	❑ $570.95
Employee + Spouse	❑ $1,171.88	❑ $1,232.60	❑ $1,260.31
Employee + Child(ren)	❑ $848.35	❑ $892.16	❑ $912.83
Family	❑ $1,375.38	❑ $1,446.75	❑ $1,478.86
Waive	❑		

DENTAL – DELTA DENTAL OF KS:	BASE	BUY-UP
Employee Only	❑ $31.51	❑ $35.29
Employee + Spouse	❑ $63.02	❑ $70.59
Employee + Child(ren)	❑ $50.42	❑ $56.46
Family	❑ $108.05	❑ $121.02
Waive	❑	

VISION – SUPERIOR	MATERIALS ONLY	FULL BENEFITS
Employee Only	❑ $6.47	❑ $8.41
Employee + Spouse	❑ $12.80	❑ $16.66
Employee + Child(ren)	❑ $12.56	❑ $16.31
Family	❑ $19.10	❑ $24.81
Waive	❑	

HSA – Mutual Savings Bank:

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.
  - ☐ No

How to open you HSA

If you are newly enrolling in the HSA you will need to

1) Contact Jennifer Gumbel (JenniferG@MutualMail.com , 913-845-2556) at Mutual Savings Bank to get your account set up (a $50 deposit is required), and
2) Turn in the payroll deduction form at the end of this guide

If you are currently enrolled in the HSA you will need to complete the payroll deduction form at the end of this guide to receive district contributions and/or make your own payroll contributions.

The account must be opened and payroll deduction forms turned in to Audra Boone prior to September 1, 2017.

Flexible Spending Account (FSA) - CBIZ

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 $_____ ($2,500 plan year max.)
  - ☐ No

Dependent Care Spending Account – CBIZ:

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 – Metlife: 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 – Metlife:

Election Amount: Employee: $_____ Spouse: $ _____ Child(ren): $_____

Payroll Deduction Form for HSA Contribution

This is the election or change form for you to indicate the amount of your *payroll* contributions to be placed in the Health Savings Account (HSA) each plan year.

Please complete the following:

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER

BANK NAME	ROUTING NUMBER	ACCOUNT NUMBER

I would like to contribute the following amount to my HSA through pre-tax payroll deductions:

$ _____ per plan year. I understand that the elected amount will be deducted from my pay in equal installments**.**

Your HSA will accumulate money through your payroll contribution to reimburse you for qualified health care expenses. Your Health Savings Account belongs to you and is your financial asset even if you change employers or health plans. Your contributions to the health savings account will be made pre-tax through payroll deductions by completing this form.

Reminder: *To contribute to a Health Savings Account you must meet the following criteria:*

1) You must be covered by a Qualified High Deductible Health Plan (QHDHP), and

2) You cannot be covered by another health plan, including Medicare (other than a QHDHP or other non-QHDHP coverage permitted by law), and

3) You and/or your spouse can not participate in the medical reimbursement part of a Flexible Spending Account.

The maximum contribution amount cannot exceed the IRS stated maximums for the calendar year. The 2017 calendar year maximum is $3,400 for an Individual and $6,750 for Family. Individuals age 55 and older can make an additional $1,000 catch up contribution. Check the IRS guidelines for maximum contributions at www.treas.gov and click on Health Savings Accounts.

- I authorize my employer to reduce my pay before taxes on a "per pay period" basis as indicated above.
- I understand my payroll contribution election (if any) is for one HSA plan year and that I can add, change or revoke my HSA contribution at least once per month in accordance with the Plan's HSA rules.
- I understand that my changes must be prospective in accordance with Internal Revenue Code (IRC) rules.
- I understand that my election contributions must comply with federal regulations.
- I certify that I am eligible to make HSA contributions and I understand my Employer will rely on this certification in making the contributions to my HSA and for appropriate tax withholding and reporting.

I agree to the above deferral request and will submit this form to my Employer for processing. I also authorize my Employer to make withdrawals from my HSA in the event that a credit entry is made in error. I understand that the custodian may provide my HSA account number to my Employer to facilitate the money transfer. I further understand that the date of my payroll may differ from the date the funds are actually deposited and are available for use.

Print Name _____ Date: _____

Return this completed form to Audra Boone prior to September 1st.