Raytown C-2 School District

2018 Employee Benefits Guide

Plan Year Begins July 1, 2018

That's why we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.

Stay Healthy

- BlueKC Medical
- Delta Dental of Missouri Dental
- VSP Vision
- Raytown Schools Quality Care Clinic
- Tri-Star Flexible Spending Accounts

Work/Life Balance

- New Directions Behavioral Health Employee Assistance Program (EAP)
- Raytown Schools Wellness Center

Feeling Secure

- The Standard Group Term Life
- Combined Life and Long Term Care
- OneAmerica Short Term Disability
- InfoArmor ID Theft Protection
- Guardian Accident
- Guardian Hospital Indemnity
- Loyal American Critical Illness
- Loyal American Cancer
- Section 529 MO$T Missouri Savings for Tuition
- 403b and 457 Retirement Plans

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CONTACT INFORMATION

Benefit Enrollment
BenefitsDirect
877-523-0176
www.benefits-direct.com/raytownqualityschools

Medical
BlueKC
816-395-2270
www.mybluekc.com

Dental
Delta Dental of Missouri
800-335-8266
www.deltadentalmo.com

Raytown Schools Quality Care Clinic
CareHere Clinic
877-423-1330
www.carehere.com

Group Term Life
The Standard
800-628-8600
www.standard.com

Employee Assistance Program
New Directions Behavioral Health
800-624-5544
www.ndbh.com

Raytown C-2 School District
Payroll Department
816-268-7000

Benefit Consultant
CBIZ Benefits & Insurance Services, Inc.

Michelle Conn
816-945-5224
mconn@cbiz.com

Susan Endicott
816-945-5289
sendicott@cbiz.com

Health Savings Accounts
UMB
866-520-4472
www.hsa.umb.com

Vision
VSP Vision Care
800-877-7195
www.vsp.com

Flexible Spending Accounts
Tri-Star Systems
800-727-0182
www.tri-starsystems.com

Accident, Hospital Indemnity, Critical Illness, Cancer, Short Term Disability, Permanent Life with LTC, ID Theft
BenefitsDirect
855-615-3680
Fax: 816-841-3790
www.benefits-direct.com/raytownqualityschools

Raytown Wellness Center
Rob Brockschink
816-268-7190

CBIZ Benefits & Insurance Services is our dedicated benefits consultant, committed to providing you legendary service. CBIZ is available to answer benefit and 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.

403b and 457 Plans

ASPire Financial Services
866-634-5873
www.aspireonline.com

FTJ Fund Choice, LLC
800-379-2513
www.ftjfundchoice.com

GWN Securities Inc.
561-472-2700
www.gwnsecurities.com

Life Insurance of the Southwest
800-579-2878
www.nationallifegroup.com

AXA Equitable Life Insurance Company
800-628-6673
https://us.axa.com/home.html

Fidelity Security Life Insurance Company
800-648-8624
www.fslins.com

Horace Mann, Rick Breinin
816-272-5588
www.horacemann.com/retirementadvantage

VALIC
913-402-5000
www.valic.com

PSRS/PEERS

Missouri Retirement Systems
800-392-6848
www.psrs-peers.org

MO$T

Missouri Savings for Tuition
888-414-6678
www.missourimost.org

Workers' Compensation

CareHere Clinic
877-423-1330

Benefit Eligibility

Who is Eligible?

If you work a minimum of 30 hours per week, you are eligible to enroll in all the benefits described in this guide and required to participate in the Missouri Retirement System (PSRS/PEERS). Spouses and dependent children (dependent child's limiting age varies by coverage) are eligible for coverage as well.

If you work a minimum of 20 hours per week, you are eligible to enroll in accident insurance, cancer insurance, critical illness, term life, short term disability, permanent life with long term care, and identity theft protection as described in this guide. You are also required to participate in the Missouri Retirement System (PSRS/PEERS). Spouses and dependent children (dependent child's limiting age varies by coverage) are eligible for coverage as well.

If you work a minimum of 10 hours per week, you are eligible for the District paid basic term life as described in this guide.

All benefits are independent of each other so you can choose to participate in one, but not the other.

How to Enroll

For new employees, your first step is to review your available benefits outlined in this guide. The second step is complete the task emailed to you by the Payroll department during your on boarding process. Some coverage offered will require additional forms to apply or increase coverage. It is your responsibility to ensure all appropriate forms are turned in to BenefitsDirect in a timely manner. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualifying event.

Current employees can only enroll or change benefits during Annual Open Enrollment, unless there is a qualifying event. Please contact the Payroll department if you have a qualifying event.

When to Enroll

- Certified staff are eligible for benefits the first of the month following the date of hire.
- Classified staff must successfully complete the 60 days probationary employment period prior to being eligible.
- Annually you may make plan changes during the open enrollment period.

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. Please initiate a qualifying event in Talent Ed Records if you experience a qualified change. Qualified changes in status include: 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 due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

Benefit Overview

District Paid Benefits for Individual Employees

- Medical Insurance
- Group Term Life Insurance
- Employer-Sponsored Health Clinic
- PSRS/PEERS Retirement Contribution—District matches individual contributions
- Sick Leave, Personal Leave and Vacation Leave (Vacation applies to 12-month employees)
- Raytown Schools Wellness Center
- Employee Assistance Plan
- Professional Liability Insurance
- Unemployment Insurance
- Workers' Compensation Insurance

Quality Added Benefits

- 457 Tax Deferred Compensation Plan/Section 403(b) Pre-Tax Investment/Tax Sheltered Annuities
- Pre-Tax Health Insurance Options for Individual Employees and their Family Members with Employee Paid Premiums
- Pre-Tax Dental Insurance Options for Individual Employees and their Family Members with Employee Paid Premiums
- Pre-Tax Vision Care Insurance
- Supplemental Term Life with AD&D
- Accident Insurance Plan
- Hospital Indemnity
- Critical Illness Plan
- Cancer Insurance Plan
- Short Term Disability
- Life with Long Term Care
- Identity Theft Protection
- Section 125 Cafeteria Tax Savings Plan (Flex Spending)
- Section 529 MO$T— Missouri Savings for Tuition Program
- Direct Deposit Payroll up to two accounts: Checking and/or Savings
- Family & Medical Leave (FMLA)— per Federal Eligibility Guidelines
- Professional Development and Training

Medical Insurance

The District offers four PPO plans through Blue Cross Blue Shield of Kansas City (BlueKC). Each of these plans utilizes the Preferred-Care Blue PPO Network of providers.

- $2500 Deductible Base Plan
- $1500 Deductible Buy-Up Plan
- $1000 Deductible Buy-Up Plan
- BlueSaver QHDHP (Qualified High Deductible Plan)

BlueCross BlueShield of Kansas City

Note all four plans; base, buy-up(s), and QHDHP family plans are implemented as a pre-tax deduction as regulated by the Cafeteria 125 Plan.

The Wellness Incentive Surcharge of $35 per month will be charged to all employees who do not complete the "Wellness Incentive Requirements" as outlined by the Wellness Committee. For detailed information you can contact Human Resources or your location's Wellness Champion.

WHAT PORTION OF PREMIUM IS PAID BY THE DISTRICT*?
Employer Paid Portion is based on the "Employee Only" rate for the $2500 Deductible Base Plan pro-rated as follows:

- $652.36 District Paid for Employees working 30 hours or more per week that elect either the $1000, $1500 or $2500 Deductible plan
- $702.36 District Paid for Employees working 30 hours or more per week that elect the BlueSaver QHDHP plan.
  - Additionally, **Employees that elect the BlueSaver QHDHP during open enrollment for a July 1, 2018 effective date will receive a one-time contribution of $500 to their UMB Bank Health Savings Account on July 1, 2018.**

**** Employer paid portion of the health insurance is subject to the Missouri Retirement System (PSRS/PEERS).***

BlueKC wants you to have the tools you need to make more informed decisions about your healthcare. The Blue KC Doctor & Hospital Provider Finder on MyBlueKC.com gives you the most up-to-date search results for doctors, hospitals, or other healthcare providers in your network, along with other tools so you can learn more about a provider before you make an appointment.

To find out if your doctor participates in the BC/BS Preferred Care Blue network, use the "Find Blue KC Doctors" link on www.BlueKC.com or BCBS Physician Directory link on the District's internet and intranet Open Enrollment link. It takes you to "Find Blue KC Doctors, Hospitals and Pharmacies" online provider directory. If you have additional questions please call Blue KC directly at 816-395-2270.

BlueKC Medical Plans Monthly Employee Premiums

	$1000 PPO Buy-Up	$1500 PPO Buy-Up	$2500 PPO Base	BlueSaver QHDHP*
Employee Working 30 hours or more				
Employee Only	$183.08	$137.37	$50.00	$0.00
Employee Plus Spouse	$1,269.04	$1,163.94	$962.95	$912.95
Employee Plus Children	$909.90	$824.48	$661.06	$611.06
Family	$1,979.18	$1,835.23	$1,559.96	$1,509.96

* Employees who elect the BlueSaver QHDHP during open enrollment for a July 1, 2018 effective date will receive a one-time contribution of $500 to their UMB Bank Health Savings Account on July 1, 2018.

BlueKC Medical Plans (In Network)

	$1000 PPO Buy-Up	$1500 PPO Buy-Up	$2500 PPO Base	BlueSaver QHDHP
Network	Preferred-Care Blue PPO	Preferred-Care Blue PPO	Preferred-Care Blue PPO	Preferred-Care Blue PPO
Deductible - Individual - Family	 $1,000 $3,000	 $1,500 $4,500	 $2,500 $7,500	 $2,700 $5,400
Coinsurance	20%	20%	20%	10%
Out of Pocket Maximum* - Individual - Family	 $5,400 $12,750	 $5,750 $13,100	 $6,300 $13,200	 $4,000 $8,000
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Physician Services - Primary Care Physician Office Visit - Specialist Office Visit - Diagnostic X-Ray - Diagnostic Labs - Routine Eye Exam - Chiropractic Services	 $35 $70 Deductible then 20% $0 $35 Deductible then 20%	 $35 $70 Deductible then 20% $0 $35 Deductible then 20%	 $35 $70 Deductible then 20% $0 $35 Deductible then 20%	 Deductible then 10% Deductible then 10% Deductible then 10% Deductible then 10% Deductible then 10% Deductible then 10%
Urgent Services - Ambulance - Emergency Room - Urgent Care	 Deductible then 20% $200 copay then deductible then 20% $70 Copay	 Deductible then 20% $200 copay then deductible then 20% $70 Copay	 Deductible then 20% $200 copay then deductible then 20% $70 Copay	 Deductible then 10% Deductible then 10% Deductible then 10%
Hospital Services - Inpatient Care - Outpatient Surgery and Services - High Tech Diagnostics	 Deductible then 20% Deductible then 20% Deductible then 20%	 Deductible then 20% Deductible then 20% Deductible then 20%	 Deductible then 20% Deductible then 20% Deductible then 20%	 Deductible then 10% Deductible then 10% Deductible then 10%
Prescription Drugs - Tier 1 Generic - Tier 2 Preferred - Tier 3 Non-Preferred - **Mail order** (102 day supply)	 $12 $55 $75 $36/$165/$225	 $12 $55 $75 $36/$165/$225	 $12 $55 $75 $36/$165/$225	Deductible then $12 $55 $75 Deductible then $36/$165/$225

** Out of Pocket Maximum includes <u>all</u> copays.*

DOCTOR AND HOSPITAL FINDER

Locate a Quality Provider that Fits Your Preferences

Log into the Blue KC Doctor and Hospital Finder on MyBlueKC.com to find the most up-to-date search results for doctors, hospitals, or other healthcare providers in your network.

USE THE DOCTOR AND HOSPITAL FINDER TO SEARCH FOR QUALITY PROVIDERS

The Doctor and Hospital Finder helps you make more informed decisions using many features like **search filters**, **comparison options**, **provider reviews** and **quality information**.

An important feature of this search tool is the ability to search for a **Blue Distinction Total Care doctor**. Blue Distinction Total Care doctors focus on ***health*** care instead of sick care. These doctors go above and beyond to enhance the overall health of their patients, providing preventive services and health coaching, and supporting patients with chronic conditions to better meet their care needs.

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.)

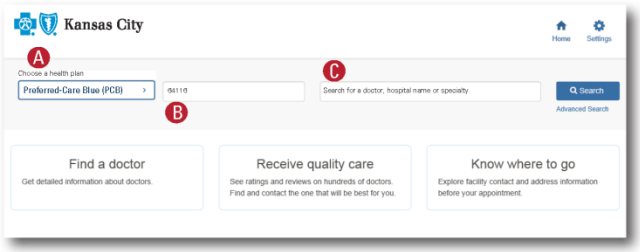
2. **After logging in**, you will see the same menu screen at the top. Click "Find a Doctor."

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.

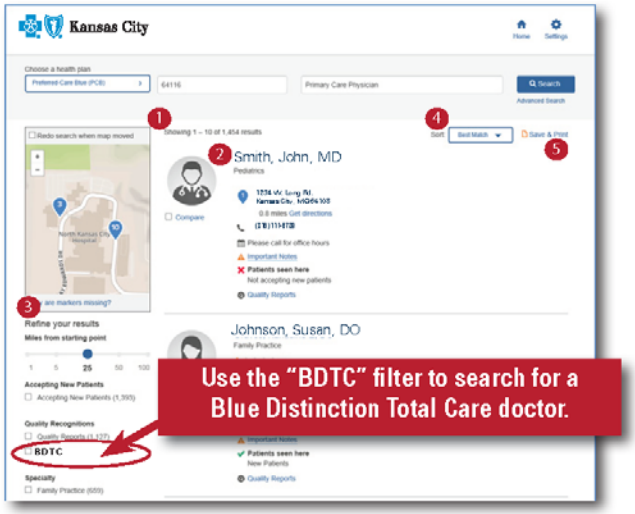
C. Search by – You can search a variety of ways; simply enter a doctor or hospital name, a health condition, or even a specialist type that treats a health condition.



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.



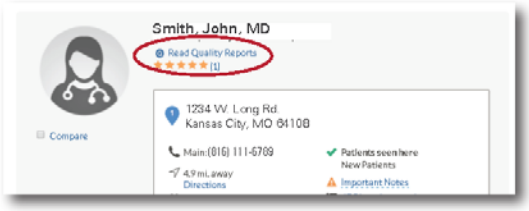
COMPARE PROVIDERS

With your search results, you can select various providers or facilities to compare.

- From your search results, select providers to compare.
- After selecting providers, you'll have a side-by-side comparison of each profile so you can see how they rank.

PROVIDER REVIEWS

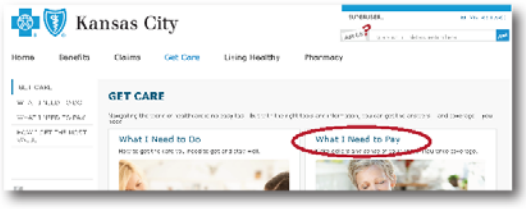
Easily read and write provider reviews and rate your care on a scale of one to five stars. Your feedback helps doctors and staff make improvements, plus, by rating your doctor, you will help others locate physicians with high patient satisfaction scores. Surveys are confidential – doctors will not know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



HAVING TROUBLE?

Please call the Customer Service number found on the back of your Blue KC member ID card.

Kansas City

MYBLUEKC.COM
Your Go-to Healthcare Resource

Navigating your healthcare coverage just got easier.

Blue Cross and Blue Shield of Kansas City (Blue KC) understands the complexities of healthcare. That's why we've developed a website specialized just for you. MyBlueKC.com is easily accessible and offers members customized information for each section of the site including:

- Personalized policy and coverage details
- Claims history
- Health information
- Cost-saving tools and more.

REGISTER ON MYBLUEKC.COM

To get started, you'll need information from your Blue KC member ID card to create your profile. Once registered and logged in, your member homepage displays important information about your Blue KC policy.

Important Notes on Registering

- You can register multiple policies with one username and password. If you have a separate Blue KC dental or medical policy, you can register both under the same user ID and password.
- All family members on your policy who are age 18 and older must register separately.

SEARCH AND GET ANSWERS

Find a Doctor

The Doctor and Hospital Finder helps you make more informed decisions using many features including:

- Provider comparison options to review providers or facilities side-by-side.
- Provider reviews to read and share patient experiences.
- Provider quality information to review certifications and recognitions.
- Doctor and hospital profiles to view specialties, plans accepted, admitting privileges and educational background.

Compare Costs for Common Procedures

The Blue KC cost forecaster tool 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**.

Find Answers

Located right on the homepage of MyBlueKC.com, you can use our Intelligent Search feature to ask a question and receive an immediate response, along with related questions in that category.

GET A SIMPLE LOOK AT YOUR COVERAGE

Benefits

Track what you have already paid, status of your deductible and out-of-pocket costs. You can also access your summary of benefits and certificate for specific details about your Blue KC policy.

Claims

Check the status of your claims and export a list of past claims (up to 24 months). You can view your claims at a summary level, expand the details, or view a copy of your Explanation of Benefits (EOB).

ACCESS PERSONALIZED CONTENT

Get Care

Learn how insurance works including what you need to do, what you need to pay and how to get the most value from your plan.

Living Healthy

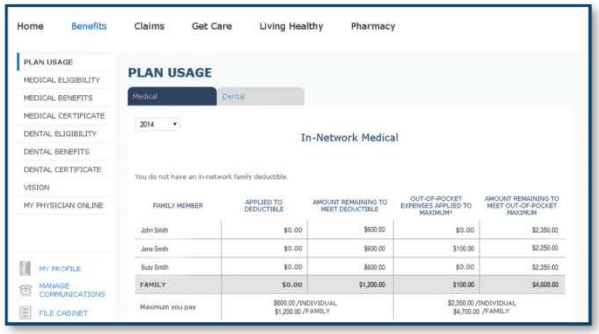
Take charge of your health. Blue KC health and wellness programs can help you: reach your health goals, manage a chronic condition or prepare for a new baby. This section also includes tools such as the Symptom Checker and more!

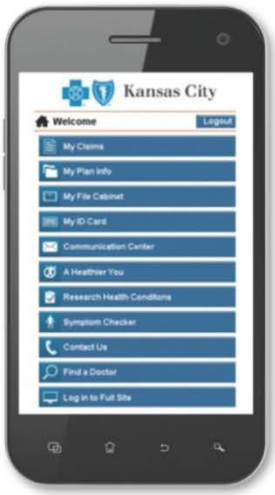
Stay Informed – How You Want

Tell us how you would like Blue KC to communicate with you. Communication categories vary, but you can pick one preference (email, text or U.S. Mail) to apply to all categories or you can customize your communication delivery preference for each category.

USE YOUR MOBILE DEVICE

Accessing MyBlueKC.com from your mobile device gives you the information you want most, anytime, anywhere. Whether you simply need to find a doctor quickly or have a moment to check on a claim, it's all at your fingertips. Before accessing our site from your mobile device, you'll need to first register with MyBlueKC.com from a desktop computer.





Kansas City

Health Savings Account (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 utilization 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 consumer driven plan. The medical plan (QHDHP) and the banking piece (HSA).

Part one, the BlueSaver QHDHP medical plan, will have a $2,700 Individual/$5,400 Family Deductible. Every covered service, including prescription drugs, will go toward the Deductible. Once you have satisfied the Out of Pocket Maximum amount, all covered medical services will be paid at 100% for the remainder of the plan year, except for copays for prescription drugs.

The BlueSaver QHDHP is accompanied by part two, a Health Savings Account (HSA). If you participate in the BlueSaver QHDHP on July 1st, you can set aside money in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. **For 2018, the District will make a one-time $500 contribution to your UMB Bank HSA, when you enroll in the BlueSaver QHDHP during open enrollment for a July 1, 2018 effective date.**

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 the BlueSaver QHDHP medical plan. Employees who are covered by any non-qualified plan (HMOs, Traditional PPOs, and Tricare), 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. Limited FSA is a flexible spending account that only reimburses you for eligible dental and vision expenses. 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 2018 calendar year is $3,450 for individual coverage and $6,850 for family coverage. 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?

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

You may use the HSA funds for the same type of things covered by a Section 125 Flexible Spending Account (e.g. dental, vision, and prescription drug out-of-pocket costs), and some things which the Section 125 plan does not allow: COBRA premium, retiree health insurance premium other than Medicare supplement policies, Long Term Care insurance premiums, and health insurance premiums if you are receiving unemployment. You can use HSA funds to pay for spouse and tax dependent children's qualified expenses, even if they are not on your medical plan.

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 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 a HSA 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 expenses for you and your dependents.

How do I open my HSA?

There are two steps to opening your HSA. First, you will need to elect to participate in the BlueSaver QHDHP and UMB HSA during enrollment. Second, you must inform your Benefits Counselor the amount you wish to contribute via payroll deductions. When you elect to participate in the UMB Bank HSA account there will be an additional monthly Administration fee of $2.50.

For additional information please contact UMB Healthcare Services at UMB Bank at 866-520-4472 or www.hsa.umb.com.

Raytown Schools Quality Care Clinic

Who Is CareHere!?

The Raytown Schools Quality Care Clinic is operated by CareHere – a passionate on-site and near-site healthcare organization that is experienced in partnering with employers to provide cost-effective healthcare and online services for their employees. CareHere is more than just a clinic. They are providing care and innovative services that are helping to change lives.

What Are the Benefits?

- Low or no-cost visits
- Low or no-cost generic medications available on-site
- Schedule appointments online with your computer, smartphone, tablet, or by calling a 24/7 help line
- Access to a 24/7 toll-free nurse line
- Little to no wait times
- More one-on-one time with a physician
- Access to telephonic health coaches

For more information on the Raytown Schools Quality Care Clinic, visit:

http://bit.ly/raytownschoolsclinic

Who Can Use the Clinic?

Benefit enrolled employees, dependents (over the age of 2), and pre-Medicare retirees of Raytown Quality Schools are eligible to receive care for personal health needs. The Clinic is open to all employees for occupational health and treatment of work related injuries, regardless of benefit enrollment.

Clinic Services

The Raytown Schools Quality Care Clinic is a resource to manage your acute illnesses and minor injuries, assist with chronic conditions, provide preventive care exams and services and support the overall health and wellness of you and your family. Below are examples of services provided in the Clinic:

Personal Health

Preventive Services

- Routine well woman and well man exams
- Preventive lab work
- Vaccinations
- Flu shot

Acute Illness (Ages 2+)

- Sore throat
- Ear infections
- Sinus infections
- Cold, flu, etc.
- Bladder infections
- Allergy care
- Headaches

Minor Injuries

- Muscle and joint pain
- Sprains and strains
- Cuts and stitches
- Mole removals

Disease Management

Including, but not limited to:

- Manage diabetes
- Cholesterol
- Blood pressure

Lab Work and Vaccinations

- Administer shots / vaccinations
- Order, conduct, interpret and consult on routine diagnostic lab work, including, but not limited to:
    - Cholesterol
    - Triglycerides
    - Blood sugar
    - Thyroid
    - Urinalysis
    - Complete blood count
    - Strep throat testing
    - Pregnancy testing

Medication

- Dispense pre-packaged medication, if available in the Raytown Schools Quality Care Clinic, or
- Prescribe medication, after thorough assessment

Diabetes Testing Supplies & Education Program

Telephonic Health Coaching

Certified health professionals trained in:

- Behavior change
- Healthy eating
- Physical activity
- Tobacco cessation
- Stress management

Sports / Camp / School Physicals

Coordination with Outside Providers

Referral to Specialists

Care Coordination

Physical Therapy

Physical therapy services for both personal health (ages 10+) and work related injuries with referral

Work Related

Worker's Related Injuries and Occupational Health

- Initial triage and follow up of work related injuries
- Drug testing
- Occupational testing
- Bus driver physicals

Location and Hours

The Raytown Schools Quality Care Clinic is conveniently located in the same building as the Raytown Schools Wellness Center at **10301 E 350 Highway, Raytown, MO 64138**.

The Raytown Schools Quality Care Clinic is currently open the following hours[1]:

Day	Primary Care	Nurse Only[2]	Worker's Compensation / Occupational Health	Physical Therapy
Monday	7 AM – 12 PM; 1 PM – 4 PM	-	-	-
Tuesday	1 PM – 6 PM	-	8 AM – 12 PM	10 AM – 12 PM
Wednesday	7 AM – 12 PM; 1 PM – 4 PM	7 AM – 12 PM	-	-
Thursday	12 PM – 6 PM	-	8 AM – 12 PM	4 PM – 6 PM
Friday	7 AM – 11 AM	7 AM – 11 AM	11 AM – 3 PM	-
Saturday/Sunday	Closed	Closed	Closed	Closed

[1] The hours of operation are subject to change. If this occurs, changes that affect the established schedule will be communicated.

[2] The nurse only hours are available for lab work, blood draws, vaccinations, blood pressure and weight checks, etc.

The Raytown Schools Quality Care Clinic will be closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day following, and Christmas Day.

Cost of Services

The Clinic will have the following cost for members enrolled in Raytown Quality Schools' medical insurance plan:

Visit Fee Schedule		$1000, $1500 or $2500 Preferred-Care Blue Plans	Preferred-Care Blue HSA Blue Saver Plan[3] *(Qualified High Deductible Health Plan)*
Preventive	**Services**	Free	Free
	Medication	Free	Free
Non-Preventive	**Services**	Free	$30[3]
	Medication	Free	$8
Physical Therapy[4]		• Before deductible is met: $30 • After deductible is met: 20% coinsurance ($6) [5] • After out-of-pocket max. is met: 0% coinsurance ($0)	• Before deductible is met: $30 • After deductible is met: 10% coinsurance ($3) • After out-of-pocket max. is met: 0% coinsurance ($0)

[3] Due to IRS regulations, a minimal visit fee is required for non-preventive visits, including chronic care or other significant benefits. The visit fee will be re-evaluated on an annual basis. This fee is still considerably less than you would pay for similar services at a physician office, urgent care center or retail clinic.

[4] Blue KC medical insurance plan visit maximums apply.

[5] Cost sharing aligns to BlueKC medical insurance plan amounts.

We want you to be prepared that the visit fee will be collected at time of service. For safety reasons, the Raytown Schools Quality Care Clinic does not accept cash. Please bring with you a Visa, MasterCard, American Express or Discover credit card. If you have an HSA debit card, this is a great time to use it!

One-Time Registration for First Time Clinic Access

Prior to scheduling your first appointment at the Clinic, you must first register with CareHere:

1. Go to www.CareHere.com
2. Click **Member Login**
3. Click **I need to register for the first time with my Access Code**
4. Enter Your Access Code (According to which plan you are enrolled in), and then click **Go**
   - **RTQS2** for $1000, $1500 or $2500 Preferred-Care Blue Plans
   - **RTHA6** for Preferred-Care Blue HSA BlueSaver Plan (Qualified High Deductible Health Plan)
5. Provide responses to all questions on the next four web pages of the health questionnaire, including **Contact Data** and **Health and Behavioral Data**
6. Create a User Name and Password

How to Schedule an Appointment

Once registered, you can schedule an appointment by calling **877-423-1330** or online at www.CareHere.com.

Please Note: Appointments are required. Please schedule an appointment prior to arriving at the Clinic. By scheduling an appointment you should expect little to no wait time. Same day appointments may be available.

Dental Insurance

The District offers a very comprehensive dental program. You have two dental options with three different networks to choose from depending on your needs. To maximize your benefits you will want to use a participating dentist. You can find a list of participating PPO and Premier dentists at www.deltadentalmo.com.

Delta Dental Low Dental (In Network)

Delta Dental PPO℠ Low Plan Features	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
	Based on applicable PPO℠ Maximum Plan Allowance – No Balance Billing	Based on applicable Premier® Maximum Plan Allowance – No Balance Billing	Based on applicable Maximum Plan allowance for Non-Participating Dentist – Dentist Balance Bills
Diagnostic and Preventive Services • Bitewing x-rays, two sets per calendar year • Full-mouth x-rays, once in any 3 year period • Periapical x-rays as required • Oral exams (all types), twice per calendar year • Prophylaxis (cleanings), twice per calendar year • Sealants for dependent children under age 15, once per tooth every 3 years, limited to caries-free first and second permanent molars • Fluoride, twice per calendar year for dependents under age 19 • Space maintainers, for dependent children under age 16, initial appliance only • Emergency palliative treatment	100%	100%	100%
Basic Services • Fillings; restorative services including composite resin (white) and amalgam (silver) • Simple extractions • Surgical extractions and other oral surgery • Endodontics: root canal filling and pulpal therapy (same tooth once in 24 month period) • Stainless steel crowns • General anesthesia, in conjunction with a covered surgical procedure	100%	80%	80%
Calendar Year Deductible (applies to Basic Services only)	$50 per person / $150 family limit		
Calendar Year Benefit Maximum	$1,250 per person		
Dependent Age Limit: End of month following 26th birthday			

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Description will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions.

Delta Dental High Dental (In Network)

Delta Dental PPO℠ High Plan Features	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
	Based on applicable PPO℠ Maximum Plan Allowance – No Balance Billing	Based on applicable Premier® Maximum Plan Allowance – No Balance Billing	Based on applicable Maximum Plan allowance for Non-Participating Dentist – Dentist Balance Bills
Diagnostic and Preventive Services • Bitewing x-rays, two sets per calendar year • Full-mouth x-rays, once in any 3 year period • Periapical x-rays as required • Oral exams (all types), twice per calendar year • Prophylaxis (cleanings), twice per calendar year • Sealants for dependent children under age 15, once per tooth every 3 years, limited to caries-free first and second permanent molars • Fluoride, twice per calendar year for dependents under age 19 • Space maintainers, for dependent children under age 16, initial appliance only • Emergency palliative treatment	100%	100%	100%
Basic Services • Fillings; restorative services including composite resin (white) and amalgam (silver) • Simple extractions • Surgical extractions and other oral surgery • Endodontics: root canal filling and pulpal therapy (same tooth once in 24 month period) • Stainless steel crowns • General anesthesia, in conjunction with a covered surgical procedure	100%	80%	80%
Major Services • Periodontal maintenance, twice per calendar year (this limit is also combined with the prophylaxis limit) • Periodontics: treatment for diseases of gums and bone supporting the teeth (Periodontal surgery is covered once in a 3 year period for the same site) (Scaling and root planning is limited to once in a 2 year period for the same site) • Prosthetics: bridges and dentures, replacements are covered once in a 5 year period but not during the first year of coverage[1] • Crowns, inlays and onlays when required for restorative purposes, replacements covered once every 5 years per tooth	50%	50%	50%
Orthodontic Services • For dependent children to age 19 that begin treatment while covered by this plan[2]	50%	50%	50%
Calendar Year Deductible (applies to Basic and Major Services only)	**$50 per person / $150 family limit**		
Calendar Year Benefit Maximum	**$1,250 per person**		
Orthodontic Lifetime Maximum	**$1,250 per eligible dependent**		
Dependent Age Limit: End of month following 26th birthday			

This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. If a discrepancy occurs the Summary Plan Description will govern.

1 The 12-month waiting period for a replacement bridge or denture is waived for all members who enroll in this plan effective 7/1/2018.

2 Delta Dental will continue providing benefits for orthodontic treatment plans that were covered by the prior carrier and in progress on 7/1/2018. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.

Delta Dental Dental Plans Monthly Employee Premiums

	Dental Low Plan	Dental High Plan
Employee Only Employee Plus 1 Dependent Employee Plus 2 or More Dependents	$23.96 $45.65 $78.02	$43.18 $83.49 $130.39

Delta Dental Networks

DELTA DENTAL PPO℠ NETWORK

Comprised of a select panel of dentists, over 207,000 dental offices nationwide participate in the Delta Dental PPO℠ program. Delta Dental will provide the highest level of benefits (see benefit highlights) for covered services when care is received from a Delta Dental PPO℠ dentist. These dentists agree to:

- **Accept payment based on the applicable PPO℠ Maximum Plan Allowance** – under this network, fewer dollars accumulate towards your annual benefit maximum, your out-of-pocket expenses are typically less and you are protected from balance billing.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

Your out-of-pocket expenses will be lowest when you see a Delta Dental PPO℠ dentist.

DELTA DENTAL PREMIER® NETWORK

Comprised of over 292,000 participating dental offices nationwide, Delta Dental Premier® offers you greater access to dentists while still offering the advantages of a network. These dentists have participating agreements with Delta Dental which require them to:

- **Accept payment based on the applicable Premier® Maximum Plan Allowance** – these dentists have agreed to accept this as payment in full which means you are protected from balance billing.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

The Delta Dental Premier® Network offers you cost control and claims filing advantages as noted above. However, your out-of-pocket expenses (deductibles and coinsurance amounts) may be higher with a Premier® dentist, based upon your plan design.

NON-PARTICIPATING DENTIST

If you receive services from a non-participating dentist (does not participate in either Delta Dental network):

- You may be responsible for filing your own claim forms.
- Delta Dental's benefit payment will be made directly to you.
- Benefit payments will be based on Delta Dental's non-participating Maximum Plan Allowance.
- You will be responsible for the difference between the dentist's charge and Delta Dental's non-participating Maximum Plan Allowance.

Your out-of-pocket expenses may be more when you use a non-participating dentist.

Vision Insurance

Did you know that a routine eye exam can help to diagnose an array of medical conditions, including diabetes? It is just as important to get your annual eye exam as it is to get your routine medical physical. The following vision plan is available to you and your family members.

To identify participating VSP providers, you may go to www.vsp.com or call 1-800-877-7195.

VSP Vision Plan* (In Network)

	Vision
Network	VSP Signature
Copays	
- Exams	$10
- Prescription Glasses	$25
- Lenses	
Anti-reflective	$35
Standard progressive lenses	$50
Premium progressive lenses	$80 – $90
Custom Progressive lenses	$120 – $160
- Contact Lens Fitting and Evaluation	Up to $60
- Diabetic Eyecare Plus Program	$20
Frequency Limitations	
Exams	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months (12 months for children under the age 18)
Diabetic Eyecare Plus Program	As needed
Allowances	
- Frames	
Wide selection	$130
Featured frame brands	$150
	20% off amount over allowance
- Contact Lenses	$130
Extra Discounts	
- Additional Glasses or Sunglasses	20 – 30% off
- Laser Vision Correction	5 – 15% off

* Please note: You will not receive a vision card for this plan.

VSP Vision Plan Monthly Employee Premiums

	VSP Vision Plan
Employee Only	$8.91
Employee Plus Spouse	$17.82
Employee Plus Children	$19.07
Family	$30.46

Flexible Spending Accounts

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 (FSA). ***You must re-enroll in the plan to participate for the plan year July 1, 2018 through June 30, 2019***. You can save approximately 25 percent of each dollar spent on these expenses when you participate in a FSA. When you elect to participate in the District sponsored FSA account there will be an additional monthly Participation and Administration Fee of $4.10.

A health care FSA is used to reimburse out-of-pocket healthcare expenses incurred by you and your dependents. A Dependent Care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

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 all the money you contributed you will be able to rollover up to $500 into the following plan year. The rollover allowance does not apply to the Dependent Care FSA.

The maximum that you can contribute to the Health Care Flexible Spending account is $2,650. *Reminder: You cannot participate in the Health Care Flexible Spending Account if you participate in a Health Savings Account.*

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 following example shows how you can save money with a flexible spending account.

	Without FSAs	With FSAs
Gross Monthly Pay	$3,500	$3,500
Pre-Tax Benefits		
-Medical/Dental Premiums	$0	$300
-Medical Expenses	$0	$100
-Dependent Care Expenses	$0	$400
Total	$0	$800
Taxes		
Wages subject to tax	$3,500	$2,700
Federal Tax	$525	$405
FICA Tax (Social Security)	$268	$207
State Tax	$175	$135
Out of Pocket Expenses	$800	$0
Total Spendable Income	**$1,732**	**$1,953**
Net Increase in Take-Home Pay = $221/mo		
This is just an illustration and actual numbers may vary. Paying certain qualified expenses before tax increases your take-home pay		

The IRS Code requires that the elections you make during the enrollment period must stay in effect for the entire Plan Year, unless you experience a ***"qualifying change in status event"***. You can make limited changes in your selections if your status changes for one of the following reasons:

- Change in employee's legal marital status - including marriage, divorce, death of spouse, legal separation, and annulment.
- Change in number of dependents - including birth, adoption, placement for adoption, and death.
- Change in employment status - including the employment status of the employee, the employee's spouse or the employee's dependent.
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements.
- A significant change in the coverage or the cost of dependent care coverage.

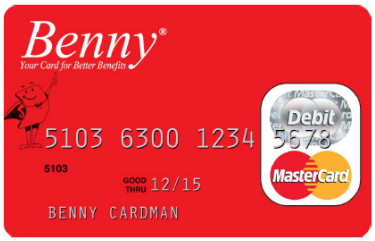
If you experience a "qualifying change in status event", and you wish to modify your benefit selections, you must notify the Human Resources department within 30 days of the change. Health Care Spending Account elections cannot be reduced below the amount already reimbursed due to qualifying events.

What type of expenses can I claim in my Health Care Reimbursement Account?

As a general rule you can include medical and dental expenses you, and/or legal dependents, incur during a plan year that are not eligible for reimbursement from other sources. These expenses include services provided by physicians, surgeons, specialist, dentist, and other medical practitioners. You may also include items such as prescription drugs, artificial limbs, crutches, wheelchairs, special construction to accommodate the handicapped person, and a host of other expenses. Our HCRA Worksheet at www.Tri-Starsystems.com website contains a general list of eligible expenses which, if not covered by another plan, would be reimbursable. These expenses are eligible for reimbursement regardless of whether or not you and/or your dependents are covered by your employer's insurance plans. Please refer to IRS Publication 502 at www.irs.ustreas.gov/pub/irs-pdf/p502.pdf for a detailed explanation of allowed and disallowed expenses.

All Healthcare FSA accounts will receive a FSA Debit Card.

Using the FSA debit card pays your medical provider with funds available in your account. Your provider is paid when the transaction is approved. However, you may be required (under IRS regulations) to support this transaction with a statement showing the services provided. Use of the card is optional and may eliminate some substantiation requirements.



Group Term Life with AD&D

The District provides a basic $15,000 term life insurance with accidental death and dismemberment (AD&D) benefit at no cost if you are an active employee working 10 or more hours per week. Please be sure your beneficiary information is up to date for all life insurance coverage.

Supplemental Term Life with AD&D

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: During the District's annual open enrollment, if you are currently enrolled in Supplemental Term Life for an amount less than $200,000 you may elect to increase your coverage amount each year by $10,000 (one increment) without having to submit evidence of insurability. Coverage over $200,000 to a maximum of $500,000 is available with medical questions. Your coverage may not exceed 6 times your annual earnings.
- Spouse*: You may purchase coverage for your eligible spouse in units of $5,000 to a maximum of $250,000. Evidence of insurability is required for your spouse if you would like to increase coverage or enroll in this benefit. Spousal coverage may not exceed 100 percent of your additional life coverage.
- Children*: You may purchase coverage for your eligible children between the ages of birth and the end of the month in which they turn 26 in the amount of $10,000.
- Age Reduction: Term life insurance reduces in coverage value as you age. The amount of life insurance and the principal sum of coverage will decrease by 35% at age 65 and by 50% at age 70.

**** In order to purchase supplemental term life insurance for your spouse or children, you as an employee must enroll and purchase supplemental term life.***

Special Underwriting for **Initial Offering Only**

Guaranteed Issue (No evidence of insurability):

$200,000 employee / $25,000 spouse / $10,000 children

Supplemental Term Life with AD&D Monthly Employee Premiums

Employee Coverage

Employee's Age *As of July 1, 2018*	Monthly Rate *(per $1,000 of total coverage)*
< 25	$0.070
25 – 29	$0.076
30 – 34	$0.082
35 – 39	$0.101
40 – 44	$0.137
45 – 49	$0.198
50 – 54	$0.296
55 – 59	$0.467
60 – 64	$0.613
65 – 69	$1.028
70 – 74	$1.815
75 +	$3.092

Spousal Coverage

Employee's Age *As of July 1, 2018*	Monthly Rate *(per $1,000 of total coverage)*
< 25	$0.070
25 – 29	$0.076
30 – 34	$0.082
35 – 39	$0.101
40 – 44	$0.137
45 – 49	$0.198
50 – 54	$0.296
55 – 59	$0.467
60 – 64	$0.613
65 – 69	$1.028
70 – 74	$1.815
75 +	$3.092

Child(ren) Coverage monthly rate is $0.90 for $10,000 regardless of the number of eligible children covered.

Accident Insurance

Accident coverage can protect your whole family

A voluntary accident plan offers coverage for accidents, injuries, ambulance services, and accidental death in addition to your primary medical insurance. It's also available to your spouse and children – a plan that can protect your whole family.

Why do I need accident coverage?

Accidents happen every day. Did you know almost 39 Million emergency room visits a year are due to an injury?[1] If you were injured from an accident, chances are you will have expenses that you were not anticipating - will you be prepared? Accident Insurance can help you deal with those expenses. Benefit payments can help you with your medical deductibles and co-pays, and cover household expenses like groceries, mortgage payments and childcare, which can begin to pile up if you have to take some time off from work. You are guaranteed coverage.

[1]Injury Facts, 2011 Edition, national Safety Council

What does accident coverage do?

Accident insurance provides you with valuable primary benefits for accidents that occur on and off the job. Features include:

- **Accident Medical Expense:** pays actual charges, up to the amount selected, for physician's treatment or other emergency treatment
- **Ambulance Benefit:** pays actual charges, up to policy amount, for ground ambulance service and emergency air transportation
- **Hospital Confinement:** pays a daily benefit for hospital room charge for a maximum of one year, up to the amount selected, when the injury is a result of a covered accident

Protect your financial security

Payroll deduction makes it easy for you to pay for accident coverage. You'll feel good knowing benefits are paid up to the amount selected for each accident, and is in addition to any other coverage you may have. Coverage starts at "zero" with each new accident. There's no calendar-year maximum.

Guardian Accident Insurance Monthly Employee Premiums (Age 18 – 70)

Monthly Rate	Value Plan	Advantage Plan
Employee Only	$14.63	$22.45
Employee Plus Spouse	$22.17	$34.22
Employee Plus Children	$29.36	$38.40
Family	$36.90	$50.17

GUARDIAN

COVERAGE – DETAILS	Option 1: Value Plan	Option 2: Advantage Plan
ACCIDENTAL DEATH AND DISMEMBERMENT		
Benefit Amount(s)	Employee $25,000 Spouse $15,000 Child $10,000	Employee $50,000 Spouse $25,000 Child $15,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500	$2,500
WELLNESS BENEFIT - Per Year Limit	$100	$100
Child(ren) Age Limits	Children age birth to 26 years	Children age birth to 26 years
FEATURES		
Accident Emergency Room Treatment	$150	$175
Accident Follow-Up Visit – Doctor	$25 up to 6 treatments	$50 up to 6 treatments
Air Ambulance	$500	$1,000
Ambulance	$100	$150
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.	$100	$125
Blood/Plasma/Platelets	$300	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn - Skin Graft	50% of burn benefit	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate.	20% increase to child benefits	20% increase to child benefits
Chiropractic Visits	No Benefit	$25 per visit up to 6 visits
Coma	$7,500	$10,000
Concussions	$50	$75
Dislocations	Schedule up to $3,600	Schedule up to $4,400

FEATURES (Cont.)	Option 1: Value Plan	Option 2: Advantage Plan
Diagnostic Exam (Major)	$100	$150
Emergency Dental Work	$200/Crown, $50/Extraction	$300/Crown, $75/Extraction
Epidural pain management	$100, 2 times per accident	$100, 2 times per accident
Eye Injury	$200	$300
Family Care	$20/day up to 30 days	$20/day up to 30 days
Fracture	Schedule up to $4,500	Schedule up to $5,500
Hospital Admission	$750	$1,000
Hospital Confinement	$175/day - up to 1 year	$225/day - up to 1 year
Hospital ICU Admission	$1,500	$2,000
Hospital ICU Confinement	$350/day - up to 15 days	$450/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$50	$75
Joint Replacement (hip/knee/shoulder)	$1,500/$750/$750	$2,500/$1,250/$1,250
Knee Cartilage	$500	$500
Laceration	Schedule up to $300	Schedule up to $400
Lodging - The hospital must be more than 50 miles from the insured's residence.	$100/day, up to 30 days for companion hotel stay	$125/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$500	$500
Surgery	Schedule up to $1,000 Hernia: $125	Schedule up to $1,250 Hernia: $150
Surgery - Exploratory or Arthroscopic	$150	$250
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$400, 3 times per accident	$500, 3 times per accident
X – Ray	$20	$30

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passenger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accommodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Accident Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan.
The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Hospital Indemnity

About Your Hospital Indemnity Insurance

Focus on recovery during a hospital stay – not your out-of-pocket costs. A hospital confinement due to an illness or injury can happen to anyone. Staying in the hospital after an accident or illness can be costly. Even quality medical plans can leave you with extra expenses to pay. Costs like plan deductibles, copays for doctor visits and extra costs for out-of-network care can add up fast. Having the financial support you may need when the time comes means less worry for you and your family.

Why Do I Need Hospital Indemnity Insurance?

Hospital Indemnity insurance benefit payments are made directly to you, no matter what other coverage you may have, and can be used however you choose. These benefit payments can help pay for out-of-pocket healthcare costs or other household expenses which can pile up during a hospital stay. Hospital Indemnity insurance helps provide financial peace of mind

Guardian Hospital Indemnity Insurance Monthly Employee Premiums (Age 18 – 69)

	Guardian Hospital Indemnity Plan
Employee Only	$13.93
Employee Plus Spouse	$25.68
Employee Plus Children	$21.85
Family	$33.60

Benefits	Hospital Indemnity
Hospital/ICU Admission	$500 per admission, limited to 1 admission(s) per insured and 2 admission(s) per covered family per benefit year.
Hospital/ICU Confinement	$100/$200 per day, limited to 15 day(s) per insured per benefit year.
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 month look back, 12 month exclusion
Child(ren) Age Limits	Children age birth to 26 years

UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

- Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.
- Premium will be waived if you are hospitalized for more than 30 days.
- Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.
- Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefit.
- After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.

Critical Illness Plan

Why Do I Need Critical Illness Insurance?

Heart disease is the leading cause of death in the United States and strokes affect about 795,000 people each year, according to the American Heart Association. Our Critical Illness coverage will pay a lump sum benefit to you which will help with the treatment costs of these health events.

Covered Illnesses:

- Heart Attack (100%)
- Organ Transplant (100%)
- Paralysis (100%)
- Stroke (100%)
- Coma (100%)
- Severe Burn (100%)
- Bypass Surgery (25%)
- Renal Failure (100%)
- Angioplasty (25%)

- ❑ $50 Annual Health Screening Benefit (60 day waiting period on wellness benefit)
- ❑ Reoccurrence Benefit for multiple situations
  - o Pays 100% of initial benefit (Events must be separated by 180 days)
- ❑ Employee chooses: **$10,000** to **$30,000** of coverage
- ❑ Coverage underwritten by Loyal American Life Insurance Company
- ❑ **$30,000** Employee Guarantee Issue Amount
- ❑ **$15,000** Spouse Guarantee Issue Amount
- ❑ **$3,000** Child Guarantee Issue Amount

BenefitsDirect Insurance Network

Loyal American Life Insurance Company

Critical Illness Monthly Employee Premiums (Base Only with $50 Health Screening Benefit and 100% Reoccurence/Additional Occurrence)

Monthly Rate	Issue Age	$10,000	$20,000	$30,000
Individual	Under 30	3.71	5.75	8.15
	30 – 39	5.94	9.82	14.25
	40 – 49	11.68	20.26	29.91
	50 – 59	19.90	35.22	52.35
	60 – 69	31.23	55.87	83.31
Single Parent Family	Under 30	3.76	5.84	8.27
	30 – 39	6.02	9.97	14.46
	40 – 49	11.85	20.56	30.36
	50 – 59	20.20	35.75	53.14
	60 – 69	31.69	56.71	84.55
Two Parent Family	Under 30	5.89	8.92	12.55
	30 – 39	9.44	15.23	21.95
	40 – 49	18.57	31.40	46.06
	50 – 59	31.64	54.59	80.62
	60 – 69	49.65	86.60	128.29

Critical Illness Monthly Employee Premiums (Base + Cancer Rider with $50 Health Screening Benefit and 100% Reoccurence/Additional Occurrence)

Monthly Rate	Issue Age	$10,000	$20,000	$30,000
Individual	Under 30	7.17	12.12	17.18
	30 – 39	11.48	20.70	30.03
	40 – 49	22.59	42.69	63.03
	50 – 59	38.49	74.21	110.31
	60 – 69	60.40	117.72	175.53
Single Parent Family	Under 30	7.42	12.55	17.78
	30 – 39	11.88	21.42	31.08
	40 – 49	23.38	44.19	65.24
	50 – 59	39.84	76.81	114.17
	60 – 69	62.52	121.84	181.68
Two Parent Family	Under 30	11.25	19.02	26.95
	30 – 39	18.02	32.48	47.11
	40 – 49	35.45	66.98	98.89
	50 – 59	60.39	116.43	173.08
	60 – 69	94.77	184.71	275.41

Critical Illness coverage can help offset initial out-of-pocket costs when help is needed most.

- For Issue Ages 18 – 69
- Employee May Apply for Individual, Single Parent Family or Two Parent Family Coverage
- Employee Selects Level of Coverage Desired from $ 10,000 to $30,000
- Two Parent Family Rates Include Automatic Spouse Coverage at 50% of Employee's Selected Coverage
- Single Parent and Two Parent Family Rates Include Automatic Child Coverage at 10% of Employee's Selected Coverage

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- Optional Rider Available for First Occurrence, Additional Occurrence or Reoccurrence of Cancer
- First Occurrence Benefit for the Employee is 100% of Benefit Face Amount (Each Insured Person is Limited to the Payment of Only One 1st Occurrence Benefit.)
- For Each Additional Occurrence or Reoccurrence (After 180 Days Past the Last Covered Occurrence) of a Covered Critical Illness, the Benefit is 50% or 100% of the Original Benefit Face Amount Which Varies for the Employee, Spouse and Children

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- Angioplasty or First Coronary Artery Bypass Surgery Benefit Is 25% of Insured's First Occurrence Benefit (Any First Occurrence Benefit amount payable for Heart Attack will be reduced, dollar for dollar, by any amounts previously paid for either Angioplasty or Coronary Artery Bypass Surgery. We will not pay any amount for Angioplasty or Coronary Artery Bypass Surgery if we have already paid the full First Occurrence Benefit for Heart Attack. We will not pay a partial First Occurrence Benefit for more than (1) Angioplasty nor more than (1) Coronary Artery Bypass Surgery per Insured Person.)
- Annual Health Screening Benefit of $50 or $100 Per Year, Depending on Selection, for Employee and Spouse
- Spouse may continue coverage if Employee dies
- Benefits Reduce 50% for any Covered Person above age 70 on the Date of Diagnosis

Benefit Payment Conditions

Payment of any benefit amount shall be subject to the following conditions:

(i) diagnosis must be made within the U.S.; and

(ii) the Date of Diagnosis shall occur while the Insured Person is covered by an issued Certificate.

Exclusions and Limitations

THIS IS A LIMITED CERTIFICATE that is designed to help cover the costs associated with Critical Illness. It should be used to supplement your existing health care protection.

PRE-EXISTING SICKNESS OR INJURY PROVISION:

The benefits of any issued Certificate will not be payable during the first twenty four (24) months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Sickness or Injury disclosed or not disclosed on the enrollment form. This 24-month period is measured from the effective date of coverage for each Insured Person.

A Pre-Existing Sickness or Injury means:

1. the existence of symptoms which would cause an ordinarily prudent person to seek medical diagnosis, care and treatment within one year before the effective date of an Insured Person's coverage ; or
2. a Sickness or Injury which is diagnosed by a Physician or for which medical advice or treatment was recommended or received from a Physician within twenty four (24) months prior to the effective date of coverage for each Insured Person.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: Any issued Certificate only pays for loss resulting from covered conditions, as defined in the Certificate: THE CERTIFICATE DOES NOT COVER:

1. intentionally self-inflicted Injury or Sickness;
2. suicide or attempted suicide, while sane or insane;
3. treatment of Mental or Nervous Disorders, alcoholism or chemical dependency;
4. loss that begins prior to the effective date of coverage;
5. care and treatment received outside the United States or its territories;
6. injuries or Sickness due to an act of declared or undeclared war;
7. any loss sustained or contracted as the result of an Insured Person being physically or mentally impaired due to being under the influence of alcohol or any narcotic unless administered on the advice of a Physician;
8. any loss to which a contributing cause was the commission of or an attempt to commit a felony. Nor will We be liable for any loss to which a contributing cause was being engaged in an illegal activity;
9. Injuries or Sickness due to participation in any sport or sporting activity for wage, compensation or profit; or
10. any illness specifically excluded from the definition of any Critical Illness; or as specifically described in any exclusionary endorsement issued with any Certificate.

EXCLUSIONS FOR CANCER BENEFIT CERTIFICATE RIDER

This rider provides benefits only for Cancer and Carcinoma-in-Situ. No benefit is payable for the diagnosis of Skin Cancer, premalignant conditions or conditions with malignant potential, including, but not limited to severe cervical dysplasia (Class III and IV) and CIN (cervical intraepithelial neplasm). This rider does not provide benefits for any other disease, sickness or incapacity.

RENEWABILITY

This Certificate will terminate when the Group Master policy terminates; when required premium remains unpaid after expiration of the Grace Period; or when the maximum available benefits have been paid.

PREMIUM RATES

We may change the premium rates for this Certificate only if we also change the rates for all other Certificates issued under the Group Master policy.

NOTE: This is a brief summary of the Certificate of Critical Illness and Cancer Benefit Certificate Rider. Coverage as described in this guide is provided only through the issuance of a Certificate. The Certificate and rider should be consulted for full terms and conditions of coverage.

Cancer Insurance

No one wants to experience a cancer diagnosis, but the fact is that the risk of getting cancer is great. In the United States, men have slightly less than a one in two lifetime risk of developing cancer; for women, the risk is a little more than one in three (Cancer Facts and Figures 2012, American Cancer Society). Our cancer/specified-disease insurance policy is designed to provide you with cash benefits during covered cancer treatments.

Why do I need cancer coverage?

A supplemental cancer insurance policy can also help protect your income and savings from expenses that aren't covered by your major medical coverage, including:

- Out-of-pocket medical expenses
- Experimental cancer treatment
- Travel and lodging when treatment is far from home
- Out-of-network specialists
- Drug trials and special diet needs

While you can't always predict the future, we believe it's good to be prepared. Our cancer insurance is here to help you and your family better cope financially and emotionally if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be lying ahead.

Here's how it works

Benefit payments are made directly to you in most cases, placing you in control at a time when you may feel that your options are limited. The first occurence diagnosis benefit is available to you after your initial diagnosis of internal cancer, so it's there when you need it most. You'll save on your premiums because coverage through your employer typically is less expensive than purchasing on your own. And you can pay premiums through automatic payroll deduction. You can continue the coverage even if you change employers.

Act now

You've probably taken some steps to protect your assets and future financial stability with a health plan, life insurance, savings, etc. Take an additional step to round out your coverage and help you and your loved ones financially in the event of an unexpected cancer occurrence.

Cancer Insurance Monthly Employee Premiums

Monthly Rate	Plan 1 (Low Plan)	Plan 2 (High Plan)
Employee	$23.50	$33.32
Single Parent	$26.64	$37.91
Family	$37.68	$53.59

BenefitsDirect Insurance Network

Loyal American Life Insurance Company

Benefit Provisions

We will pay the benefits described in the Certificate for the treatment of an Insured Person's Cancer, provided he or she is covered under an issued Certificate which remains in force. Payment will be made in accordance with all applicable policy provisions. Benefits are payable for a positive diagnosis that begins after the Effective Date. The positive diagnosis must be for Cancer as defined in the policy.

POSITIVE DIAGNOSIS BENEFIT: We will pay the **Actual Charge but not to exceed $300 per Calendar Year** for one test that confirms the Positive Diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

NATIONAL CANCER INSTITUTE DESIGNATED COMPREHENSIVE CANCER TREATMENT CENTER EVALUATION/CONSULTATION BENEFIT: We will pay the Actual Charge, but **not to exceed a lifetime maximum of $750**, if an Insured Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred but **not to exceed a lifetime maximum of $350**. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. ***This benefit is payable one time during the lifetime of the Insured Person***.

SECOND AND THIRD SURGICAL OPINION EXPENSE BENEFIT: We will pay the **Actual Charge** for a written second surgical opinion concerning the recommendation of Cancer surgery and if the second surgical opinion is in conflict with that of the Physician originally recommending the surgery and the Insured Person desires a third opinion, We will the Actual Charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

MEDICAL IMAGING, TREATMENT PLANNING AND MONITORING EXPENSE BENEFIT: We will pay the **Actual Charge, but not to exceed $1,000 per Calendar Year**, for laboratory tests, diagnostic X-rays, medical images, when used in Cancer treatment plannings related to Radiation Treatment, Chemotherapy or Immunotherapy.

ANTI-NAUSEA MEDICATION EXPENSE BENEFIT: We will pay the **Actual Charge for anti-nausea medication, but not to exceed $150 per calendar month**, when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

COLONY STIMULATING FACTOR OR IMMUNOGLOBULIN EXPENSE BENEFIT: We will pay the **Actual Charge but not to exceed $1,000 per Calendar Month** for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.

OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER EXPENSE BENEFIT: We will pay the **Actual Charge** from an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities for the performance of a surgical procedure covered under this Policy but **not to exceed $350 per day**.

PROSTHESIS EXPENSE BENEFIT: (A.) **Surgically Implanted Breast Prosthesis** – We will pay the **Actual Charge** for a surgically implanted prosthetic device required and prescribed to restore normal body contour lost as the direct result of an Insured Person's breast removal for the treatment of Cancer. The Surgically Implanted Breast Prosthesis Benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider.

(B.) **Non-Surgically Implanted Prosthesis:** We will pay the **Actual Charge incurred not to exceed $2,000 per amputation** for an artificial limb or other non-surgically implanted prosthetic device that is prescribed and required to restore normal body function lost as the direct result of an Insured Person's amputation for the treatment of Cancer. We will pay a **lifetime maximum of $2,000 per amputation**. The cost of replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

NON-LOCAL TRANSPORTATION EXPENSE BENEFIT: We will pay the **Actual Charge, but not to exceed the coach fare on a Common Carrier for the Insured Person and one adult companion's travel** to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private **vehicle mileage allowance of $.50 per mile** for Non-Local transportation in lieu of the common carrier coach fare.

LODGING EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $75 per day** for a room in a motel, hotel or other appropriate lodging facility (other than a private residence), when an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center. The room must be occupied by the Insured Person or an adult companion which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. **This benefit is limited to 100 days per Calendar Year**.

INPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Inpatient.

OUTPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Outpatient.

BONE MARROW DONOR EXPENSE BENEFIT: *We will pay the Daily Hospital Confinement Benefit shown on the Certificate Schedule* for each day a live donor, other than the Insured Person, is confined in a Hospital for the harvesting of bone marrow or stem cells used in a bone marrow or stem cell transplant for the treatment of an Insured Person's Cancer.

BONE MARROW OR STEM CELL TRANSPLANT EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed a lifetime maximum of $15,000 for surgical and anesthesia procedures** (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Cancer. This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to an issued Certificate.

AMBULANCE EXPENSE BENEFIT: We will pay the **Actual Charge** for ambulance service if an Insured Persons is transported to a Hospital where he or she is admitted as an inpatient for the treatment of Cancer . The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

INPATIENT OXYGEN EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $300 per Hospital confinement** for oxygen prescribed by a Physician and received by an Insured Person while confined in a Hospital for the treatment of Cancer.

ATTENDING PHYSICIAN EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $40 per day** for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person and the amount stated is the maximum amount that will be payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

INPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $150 per day** for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital and the Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

OUTPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $150 per day** limited to the same number of days of the prior Hospital confinement for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer . This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family. Charges must begin following a period of Hospital confinement for which benefits are payable under this Certificate.

CONVALESCENT CARE FACILITY EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $100 per day** for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to a Convalescent Care Facility. The Convalescent Care Facility Confinement must: be due to Cancer ; begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer ; be authorized by a Physician as being medically necessary for the treatment of Cancer.

RENTAL OR PURCHASE OF MEDICAL EQUIPMENT EXPENSE BENEFIT: We will pay the lesser of the **Actual Charge not to exceed $1,500 per Calendar Year** for either the rental or purchase of covered medical equipment designed for home use, required and ordered by the Insured Person's attending Physician as the direct result of the treatment of Cancer. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

HOME HEALTH CARE EXPENSE BENEFIT: We will pay benefits for the following Covered Charges when a Insured Person requires Home Health Care for the treatment of Cancer.

1. **Home Health Care Visits** - We will pay the **Actual Charge for Home Health Care Visits not to exceed $75 for each day** on which one or more such visits occur. We will not pay this benefit for more than 60 days in any Calendar Year.
2. **Medicine and Supplies** - We will pay the **Actual Charge not to exceed $450 in any Calendar Year** for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. **Services of a Nutritionist** - We will pay the **Actual Charge not to exceed a lifetime maximum of $300** for the services of a nutritionist to set up programs for special dietary needs.

HOSPICE CARE EXPENSE BENEFIT: We will pay the **Actual Charge for Hospice Care not to exceed $100 per day**, when such care is required because of Cancer . This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for payments will be based on the following conditions being met:(1) the Insured Person has been given a prognosis as being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. The lifetime maximum benefit is 365 days of Hospice Care.

HAIRPIECE EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed a lifetime maximum of $150** for the purchase of a wig or hairpiece that is required as the direct result of hair loss due to Cancer treatment.

PHYSICAL, SPEECH, AUDIO THERAPY AND PSYCHOTHERAPY EXPENSE BENEFIT: We will pay the **Actual Charge not to exceed $25 per therapy session** for:

1. Physical therapy treatments given by a license Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist. These sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. **Benefits may not exceed $1,000 per Calendar Year**.

WAIVER OF PREMIUM: We will waive the premiums starting on the first premium due date **following a 60 day period of Total Disability** of the Named Insured due to Cancer. The Named Insured must: (a) be receiving treatment for such Cancer for which benefits are payable under this Certificate; and (b) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled.

Additional Benefits Included

	Level One Maximum	Level Two Maximum
ANNUAL CANCER SCREENING BENEFIT RIDER (form LG-6041)		
A. Basic Benefit We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Certificate Schedule, once per calendar year per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to: mammogram, pap smear, breast ultrasound, ThinPrep, biopsy, chest x-ray, thermography, colonoscopy, flexible sigmoidoscopy, hemocult stool specimen, PSA (blood test for prostate cancer), CEA (blood tests for colon cancer), CA125 (blood test for ovarian cancer), CA15-3 (blood test for breast cancer), serum protein electrophesis (blood test for myeloma).	$100 Per Calendar Year	$125 Per Calendar Year
B. Additional Benefit We will pay the expense incurred, but not to exceed two times the maximum benefit amount per calendar year as shown on the Certificate Schedule, for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above for an Insured Person. This additional benefit is payable regardless of the results of the additional diagnostic procedure. However, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained in the base Policy	$200 Per Calendar Year	$250 Per Calendar Year
FIRST OCCURRENCE BENEFIT RIDER (form LG-6043) If an Insured Person receives a positive diagnosis of Internal Cancer, We will pay the First Occurrence benefit amount shown on the Certificate Schedule.	$3,000 Once per Lifetime	$5,000 Once per Lifetime
If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, we will pay one and one-half times the First Occurrence benefit amount shown on the Certificate Schedule.	$4,500 Once per Lifetime	$7,500 Once per Lifetime
ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT BENEFIT RIDER (form LG-6045) We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Certificate Schedule, per calendar year per Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment must be for the treatment of an Insured Person's Cancer. The benefit amount shown on the Certificate Schedule is the maximum calendar year benefit available per Insured Person regardless of the number or types of Cancer treatments received in the same year.	$10,000 Per Calendar Year	$15,000 Per Calendar Year
SURGICAL BENEFIT RIDER (form LG-6048) **Surgical Expense**: We will pay the Surgical Expense benefit for a surgical procedure for the treatment of an Insured Person's Cancer (except Skin Cancer) according to the Surgical Schedule shown in this rider. However, in no event will the amount payable exceed the maximum Surgical Expense benefit shown on the Certificate Schedule, nor will it exceed the expense incurred.	$3,000 Procedure Maximum	$5,000 Procedure Maximum
Anesthesia Expense: We will pay the anesthesia expense incurred, not to exceed 25% of the covered Surgical Expense benefit for the operation performed. This includes the services of an anesthesiologist or of an anesthetist under supervision of a physician for the purpose of administering anesthesia.		
Breast Reconstruction with transverse rectus adominis myocutaneous flap (TRAM), single pedicle, including closure of donor site, with microvascular anastomosis (supercharging) is one of the surgical procedures listed in the Surgical Schedule. If this procedure is performed on an Insured Person as the result of a mastectomy for which We paid a Surgical Expense benefit for the treatment of Breast Cancer, We will pay the expense incurred not to exceed $900 per $1,000 of the Surgical Benefit issued.		

Skin Cancer Surgery Expense: We will pay the expense incurred, not to exceed the procedure amount listed in this rider ($125 to $750 depending on the procedure) when a surgical operation is performed on an Insured Person for treatment of a diagnosed Skin Cancer. This benefit is payable in lieu of any benefits for Surgical Expense and Anesthesia Expense which are not applicable to Skin Cancer.		
DAILY HOSPITAL CONFINEMENT BENEFIT RIDER (form LG-6042)	$100 Per Day	$200 Per Day
Confinements of 30 Days or Less: We will pay the Daily Hospital Confinement benefit amount shown on the Certificate Schedule for each of the first 30 days in each period of hospital confinement during which an Insured Person is confined to a hospital, including a government or charity hospital, for the treatment of Cancer.		
Confinements of 31 Days or More If an Insured Person is continuously confined to a hospital, including a government or charity hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement benefit amount shown on the Certificate Schedule. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital.	$200 Per Day	$400 Per Day
Benefits for an Insured Dependent Child under Age 21 The amount payable under this benefit will be **double the Daily Hospital Confinement benefit** shown on the Certificate Schedule if the Insured Person so confined is a dependent child under the age of 21.	$200/ $400 Per Day	$400/ $800 Per Day

THIS IS A CANCER ONLY POLICY, which should be used to supplement your existing health care protection.

RENEWABILITY: Coverage will terminate when the Group Master Policy terminates or when required premium remains unpaid after expiration of the Grace Period.

PREMIUM RATES: We may change the premium rates for coverage only if we also change the rates for all other Certificates issued under the Group Master Policy.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under the Certificate or any attached riders for: 1. any loss due to any disease or illness other than Cancer, or a listed covered Specified Disease; 2. care and treatment received outside the territorial limits of the United States; 3. Treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined; 4. treatment that has not been approved by a Physician as being medically necessary; or 5. losses or medical expenses incurred prior to the Certificate Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

PRE-EXISTING CONDITIONS LIMITATION: Relative to any Insured Person, We will not pay benefits for expenses resulting from Pre-existing Conditions during the 12 months after coverage becomes effective.
"Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within 1 year prior to the effective date of coverage for each Insured Person.

Short Term Disability

OneAmerica Short Term Disability plan can replace a portion of your income if you become ill or injured and cannot perform the duties of your job.

Plan 1

Full-time Employee Requirement	An eligible employee is a full-time permanent employee authorized to work and reside in the United States. Eligible employees must work 20 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If any eligible employee is not actively at work on the individual effective date, group insurance coverage for that employee will not exist until he/she returns to fulltime active work.
Benefit Amount	Increments of $100 per month, not to exceed 60% of an Employee's Covered Monthly Earnings to a maximum benefit of $6,000, then reduced by Other Income Benefits as outlined in the certificate. The minimum weekly benefit is $25.
Definition of Earnings	Basic monthly earnings only: The amount of coverage will be based upon earnings as last reported in writing to and approved by AUL. In no event will the amount of earnings used to calculate benefits under the AUL contract exceed the lesser of the amount approved by AUL, amount shown in the Employer's payroll records, or for which premium has been paid.
Elimination Period	7 days for injury or 7 days for sickness. This is the period of consecutive days of disability for which no benefit is payable.
Maximum Benefit Duration	26 weeks. This is the length of time that an insured Employee may be entitled to benefits if continuously disabled as outlined in the Certificate.
Maternity Coverage	Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.
Total Disability	You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular job; you are not working in any occupation and are under the regular attendance of a physician for that injury or sickness.
Partial Disability	A partial disability benefit may be paid, if because of injury or sickness an Employee, while unable to perform every material and substantial duty of your regular job on a full-time basis, is performing at least one of the material and substantial duties of your regular job, or another occupation, on a full or part-time basis, and is earning less than 80% of his or her pre-disability earnings due to the same injury or sickness.
Residual Disability	The elimination period can be met using total disability, partial disability, or a combination of both.
Recurrent Disability	A recurrent disability is the direct result of the injury or sickness that caused a prior disability. This benefit allows claim payments to continue without satisfying a new elimination period if an Employee returns to active full-time work and has a recurrent disability within 30 consecutive days of return to active work.
Pre-Existing Condition Exclusions	The pre-existing period is 3/12. Benefits will not be paid if the Person's disability begins in the first 12 months of coverage; and the disability is caused by, contributed to, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed medicines in the 3 months just prior to the Individual's effective date of insurance. Incurred expenses are not applicable in MO.
Portability	You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
Continuation of Coverage During	FMLA, Temporary Lay Off or LOA and LOA for Military Service
Exclusions	This plan may not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony.

Plan 2

Full-time Employee Requirement	An eligible employee is a full-time permanent employee authorized to work and reside in the United States. Eligible employees must work 20 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If any eligible employee is not actively at work on the individual effective date, group insurance coverage for that employee will not exist until he/she returns to fulltime active work.
Benefit Amount	Increments of $100 per month, not to exceed 60% of an Employee's Covered Monthly Earnings to a maximum benefit of $6,000, then reduced by Other Income Benefits as outlined in the certificate. The minimum weekly benefit is $25.
Definition of Earnings	Basic monthly earnings only: The amount of coverage will be based upon earnings as last reported in writing to and approved by AUL. In no event will the amount of earnings used to calculate benefits under the AUL contract exceed the lesser of the amount approved by AUL, amount shown in the Employer's payroll records, or for which premium has been paid.
Elimination Period	14 days for injury or 14 days for sickness. This is the period of consecutive days of disability for which no benefit is payable.
Maximum Benefit Duration	26 weeks. This is the length of time that an insured Employee may be entitled to benefits if continuously disabled as outlined in the Certificate.
Maternity Coverage	Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.
Total Disability	You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular job; you are not working in any occupation and are under the regular attendance of a physician for that injury or sickness.
Partial Disability	A partial disability benefit may be paid, if because of injury or sickness an Employee, while unable to perform every material and substantial duty of your regular job on a full-time basis, is performing at least one of the material and substantial duties of your regular job, or another occupation, on a full or part-time basis, and is earning less than 80% of his or her pre-disability earnings due to the same injury or sickness.
Residual Disability	The elimination period can be met using total disability, partial disability, or a combination of both.
Recurrent Disability	A recurrent disability is the direct result of the injury or sickness that caused a prior disability. This benefit allows claim payments to continue without satisfying a new elimination period if an Employee returns to active full-time work and has a recurrent disability within 30 consecutive days of return to active work.
Pre-Existing Condition Exclusions	The pre-existing period is 3/12. Benefits will not be paid if the Person's disability begins in the first 12 months of coverage; and the disability is caused by, contributed to, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed medicines in the 3 months just prior to the Individual's effective date of insurance. Incurred expenses are not applicable in MO.
Portability	You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
Continuation of Coverage During	FMLA, Temporary Lay Off or LOA and LOA for Military Service
Exclusions	This plan may not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony.

ONEAMERICA®

Plan 3

Full-time Employee Requirement	An eligible employee is a full-time permanent employee authorized to work and reside in the United States. Eligible employees must work 20 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If any eligible employee is not actively at work on the individual effective date, group insurance coverage for that employee will not exist until he/she returns to fulltime active work.
Benefit Amount	Increments of $100 per month, not to exceed 60% of an Employee's Covered Monthly Earnings to a maximum benefit of $6,000, then reduced by Other Income Benefits as outlined in the certificate. The minimum weekly benefit is $25.
Definition of Earnings	Basic monthly earnings only: The amount of coverage will be based upon earnings as last reported in writing to and approved by AUL. In no event will the amount of earnings used to calculate benefits under the AUL contract exceed the lesser of the amount approved by AUL, amount shown in the Employer's payroll records, or for which premium has been paid.
Elimination Period	30 days for injury or 30 days for sickness. This is the period of consecutive days of disability for which no benefit is payable.
Maximum Benefit Duration	26 weeks. This is the length of time that an insured Employee may be entitled to benefits if continuously disabled as outlined in the Certificate.
Maternity Coverage	Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.
Total Disability	You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular job; you are not working in any occupation and are under the regular attendance of a physician for that injury or sickness.
Partial Disability	A partial disability benefit may be paid, if because of injury or sickness an Employee, while unable to perform every material and substantial duty of your regular job on a full-time basis, is performing at least one of the material and substantial duties of your regular job, or another occupation, on a full or part-time basis, and is earning less than 80% of his or her pre-disability earnings due to the same injury or sickness.
Residual Disability	The elimination period can be met using total disability, partial disability, or a combination of both.
Recurrent Disability	A recurrent disability is the direct result of the injury or sickness that caused a prior disability. This benefit allows claim payments to continue without satisfying a new elimination period if an Employee returns to active full-time work and has a recurrent disability within 30 consecutive days of return to active work.
Pre-Existing Condition Exclusions	The pre-existing period is 3/12. Benefits will not be paid if the Person's disability begins in the first 12 months of coverage; and the disability is caused by, contributed to, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed medicines in the 3 months just prior to the Individual's effective date of insurance. Incurred expenses are not applicable in MO.
Portability	You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
Continuation of Coverage During	FMLA, Temporary Lay Off or LOA and LOA for Military Service
Exclusions	This plan may not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony.

Short Term Disability Monthly Employee Premiums

Monthly Rate	Plan 1: 7 day elimination period			Plan 2: 14 day elimination period			Plan 3: 30 day elimination period		
Age	0 – 49	50 – 59	60 +	0 – 49	50 – 59	60 +	0 – 49	50 – 59	60 +
$500	$12.63	$14.73	$19.82	$11.74	$13.70	$18.43	$7.35	$10.27	$13.82
$600	$15.15	$17.67	$23.78	$14.09	$16.43	$22.11	$8.82	$12.32	$16.58
$700	$17.68	$20.62	$27.74	$16.44	$19.17	$25.80	$10.29	$14.38	$19.35
$800	$20.20	$23.56	$31.70	$18.78	$21.91	$29.48	$11.76	$16.43	$22.11
$900	$22.73	$26.51	$35.67	$21.13	$24.65	$33.17	$13.23	$18.49	$24.88
$1,000	$25.25	$29.45	$39.63	$23.48	$27.39	$36.85	$14.70	$20.54	$27.64
$1,500	$37.88	$44.18	$59.45	$35.22	$41.09	$55.28	$22.05	$30.81	$41.46
$2,000	$50.50	$58.90	$79.26	$46.96	$54.78	$73.70	$29.40	$41.08	$55.28
$2,500	$63.13	$73.63	$99.08	$58.70	$68.48	$92.13	$36.75	$51.35	$69.10
$3,000	$75.75	$88.35	$118.89	$70.44	$82.17	$110.55	$44.10	$61.62	$82.92
$3,500	$88.38	$103.08	$138.71	$82.18	$95.87	$128.98	$51.45	$71.89	$96.74
$4,000	$101.00	$117.80	$158.52	$93.92	$109.56	$147.40	$58.80	$82.16	$110.56
$4,500	$113.63	$132.53	$178.34	$105.66	$123.26	$165.83	$66.15	$92.43	$124.38
$5,000	$126.25	$147.25	$198.15	$117.40	$136.95	$184.25	$73.50	$102.70	$138.20
$5,500	$138.88	$161.98	$217.97	$129.14	$150.65	$202.68	$80.85	$112.97	$152.02
$6,000	$151.50	$176.70	$237.78	$140.88	$164.34	$221.10	$88.20	$123.24	$165.84

Life Insurance with Long Term Care

The BenefitsDirect LifeTime Life Insurance & Long-Term Care policy provides an inexpensive mechanism for purchasing Long-Term Care (LTC) coverage. The policy is underwritten by Combined Insurance, which has an A Rating from A.M. Best.

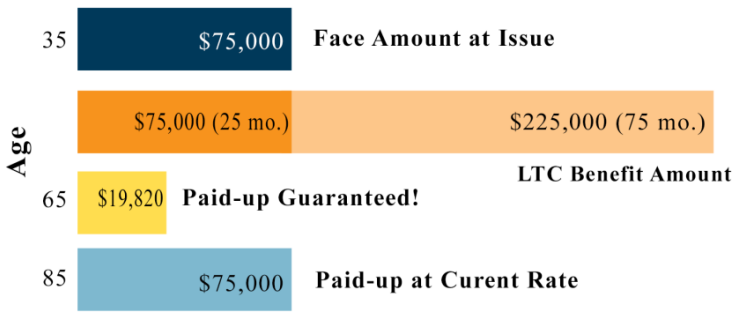
*Permanent Term Insurance that **lasts a lifetime**...finally, a benefit solution for **"Pre"** and **"Post"** Retirement needs*

Plan Features

- Life Insurance Premiums **Guaranteed** for Life
- Long Term Care coverage worth 3x your death benefit amount. That's up to 75 Months of care for Nursing Home, Assisted Living and Home Care!
- Guaranteed acceptance up to **$100,000**
- Paid-Up Insurance **starting in Tenth Year**
- Death Benefit is **Fully Paid-Up** prior to Age 100 on a current assumption basis
- Plan is **Portable** with no increase in life insurance premium
- Spouse and Children coverage available
- Accelerated Death Benefit for Terminal Illness included
- Guaranteed protection for Today and Tomorrow
- Sample rates provided on the following pages

An Example of How LifeTime Benefit Term with LTC Works

- A 35-year-old non-smoker can purchase $75,00 of coverage including the Accelerated Death Benefits for Long Term Care and Terminal Illness with Extension of Long Term Care Benefits for $12.87 weekly.
- At age 65, the employee would have guaranteed paid-up insurance at $19,820.
- At age 85, the full face amount of $75,000 would be paid-up based on current interest rates.
- Long Term Care benefits of $3,000 (4% of $75,000) per month would be available for up to 75 months.)



BenefitsDirect Insurance Network

COMBINED INSURANCE

Policy Benefits Include

Life Insurance	The policy provides Life Insurance with Guaranteed Rates to age 120, and the policy is: • Individually owned • Completely portable • Other Group Life coverage decreases with age and premiums
Accelerated Death Benefit for Long Term Care Rider	The Accelerated Death Benefit for Long Term Care Rider provides the insured the option of receiving a benefit early if needed for long term care. The insured becomes eligible for benefits by being certified by a physician as being both chronically ill and confined to a nursing or assisted living facility, or by receiving home health or adult day care services. • Benefits begin after a 90 day elimination period has been satisfied. • The monthly accelerated benefit is 4% of the base death benefit for a maximum benefit period of 75 months.
Accelerated Death Benefit for Terminal Illness	Automatically included, 50% of face amount advanced if diagnosed with Terminal Illness!
Future Purchase Option	Protects future insurability, opportunity to increase coverage on annual basis, even as health status changes!
Limited Underwriting (Initial Eligibility Period Only)	Employee coverage • Up to $100,000 if actively at work Spouse coverage • Up to $75,000 with 4 health questions Child(ren) coverage • Child's Term Rider benefit – covers all dependent children in family (18 and under on issue date, can remain on until age 23), no health questions • $25,000 Term Policy can be converted to $125,000 Term Policy at age 23

Permanent Life with Long Term Care Employee Sample Monthly Premiums (Non-Smoker)

Riders	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%
Iss Age	$ 10,000	$ 25,000	$ 50,000	$ 75,000	$ 100,000	$ 125,000	$ 150,000
19	N/A	N/A	22.75	34.12	45.50	56.87	68.25
20	N/A	N/A	22.75	34.12	45.50	56.87	68.25
21	N/A	N/A	23.17	34.75	46.33	57.91	69.50
22	N/A	N/A	23.58	35.37	47.16	58.96	70.75
23	N/A	N/A	24.04	36.06	48.08	60.10	72.12
24	N/A	N/A	24.54	36.81	49.08	61.35	73.62
25	N/A	N/A	25.04	37.56	50.08	62.60	75.12
26	N/A	N/A	25.92	38.87	51.83	64.79	77.75
27	N/A	13.44	26.87	40.31	53.75	67.18	80.62
28	N/A	13.94	27.87	41.81	55.75	69.68	83.62
29	N/A	14.44	28.87	43.31	57.75	72.18	86.62
30	N/A	14.94	29.87	44.81	59.75	74.68	89.62
31	N/A	15.57	31.15	46.72	62.30	77.87	93.45
32	N/A	16.27	32.55	48.82	65.10	81.37	97.65
33	N/A	16.95	33.91	50.86	67.81	84.77	101.72
34	N/A	17.67	35.35	53.02	70.70	88.37	106.05
35	N/A	18.50	37.00	55.50	74.00	92.50	111.00
36	N/A	19.49	38.98	58.47	77.96	97.45	116.95
37	N/A	20.52	41.05	61.57	82.10	102.62	123.15
38	N/A	21.60	43.20	64.80	86.40	108.00	129.59
39	N/A	22.78	45.56	68.33	91.11	113.89	136.67
40	N/A	23.96	47.91	71.87	95.83	119.79	143.74
41	N/A	25.25	50.51	75.76	101.01	126.27	151.52
42	N/A	26.61	53.22	79.83	106.45	133.06	159.67
43	N/A	28.01	56.02	84.03	112.05	140.06	168.07
44	N/A	29.49	58.99	88.48	117.98	147.47	176.97
45	N/A	31.06	62.12	93.18	124.25	155.31	186.37
46	13.25	33.13	66.26	99.38	132.51	165.64	198.77
47	14.14	35.34	70.68	106.02	141.36	176.70	212.04
48	15.08	37.70	75.40	113.10	150.79	188.49	226.19
49	16.06	40.14	80.28	120.42	160.56	200.70	240.84
50	17.14	42.85	85.70	128.56	171.41	214.26	257.11
51	18.17	45.43	90.85	136.28	181.71	227.14	272.56
52	19.26	48.15	96.30	144.44	192.59	240.74	288.89
53	20.39	50.97	101.95	152.92	203.89	254.86	305.84
54	21.59	53.99	107.97	161.96	215.94	269.93	323.91
55	22.85	57.12	114.25	171.37	228.49	285.61	342.74
56	24.71	61.78	123.56	185.34	247.12	308.90	370.69
57	26.70	66.75	133.50	200.25	267.01	333.76	400.51
58	28.80	71.99	143.99	215.98	287.97	359.96	431.96
59	30.99	77.46	154.93	232.39	309.85	387.32	464.78
60	33.30	83.25	166.49	249.74	332.99	416.23	499.48
61	36.25	90.63	181.26	271.89	362.52	453.15	543.78
62	39.31	98.26	196.53	294.79	393.05	491.31	589.58
63	42.56	106.40	212.79	319.19	425.58	531.98	638.37
64	45.94	114.84	229.68	344.52	459.36	574.21	689.05
65	49.50	123.75	247.49	371.24	494.98	618.73	742.47
66	55.14	137.84	275.69	413.53	551.38	689.22	827.07
67	61.04	152.61	305.22	457.83	610.44	763.05	915.66
68	67.26	168.15	336.29	504.44	672.59	840.74	1,008.88
69	73.81	184.52	369.04	553.55	738.07	922.59	1,107.11
70	80.76	201.91	403.82	605.73	807.63	1,009.54	1,211.45

Actual premiums may vary slightly due to administrative system rounding.

(*) Rider Keys: TI=Terminal Illness Accelerated Benefit: All ages, LTC75 RR50%=LTC Accelerated Benefit (excluding term riders) up to 25 months PLUS Extension of Benefits to 75 months, Restoration rider restores up to 50% of death benefits: Ages 18-70 (No EOB ages 71-80),

Initial death benefit is guaranteed to later of 25 years or age 70. After this period, death benefit is projected level to age 121. Guarantees are based upon 2.00% interest and guaranteed insurance charges. Non-guaranteed benefits include credits based upon 3.5% interest and current insurance charges. The Age Paid Up is the attained age where the initial base death benefit (excluding death benefit provided by term rider) is projected to be fully paid-up under current assumptions. The plan has no cash surrender or loan values. Underwritten by Combined Insurance Company of America.

Permanent Life with Long Term Care Employee Sample Monthly Premiums (Smoker)

Riders	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%	TI, LTC75 RR50%
Iss Age	$ 10,000	$ 25,000	$ 50,000	$ 75,000	$ 100,000	$ 125,000	$ 150,000
19	N/A	14.50	29.00	43.50	58.00	72.50	87.00
20	N/A	14.50	29.00	43.50	58.00	72.50	87.00
21	N/A	14.85	29.71	44.56	59.41	74.27	89.12
22	N/A	15.21	30.42	45.62	60.83	76.04	91.25
23	N/A	15.60	31.21	46.81	62.41	78.02	93.62
24	N/A	16.04	32.08	48.12	64.16	80.21	96.25
25	N/A	16.46	32.92	49.37	65.83	82.29	98.75
26	N/A	17.08	34.17	51.25	68.33	85.41	102.50
27	N/A	17.75	35.50	53.25	71.00	88.75	106.50
28	N/A	18.40	36.79	55.19	73.58	91.98	110.37
29	N/A	19.04	38.08	57.12	76.16	95.20	114.25
30	N/A	19.71	39.42	59.12	78.83	98.54	118.25
31	N/A	20.60	41.20	61.80	82.40	103.00	123.60
32	N/A	21.57	43.15	64.72	86.30	107.87	129.44
33	N/A	22.49	44.97	67.46	89.95	112.43	134.92
34	N/A	23.48	46.96	70.45	93.93	117.41	140.89
35	N/A	24.48	48.96	73.43	97.91	122.39	146.87
36	N/A	25.67	51.35	77.02	102.70	128.37	154.04
37	N/A	26.99	53.99	80.98	107.98	134.97	161.97
38	N/A	28.32	56.63	84.95	113.26	141.58	169.89
39	N/A	29.87	59.73	89.60	119.46	149.33	179.19
40	N/A	31.33	62.66	94.00	125.33	156.66	187.99
41	13.31	33.27	66.55	99.82	133.09	166.37	199.64
42	14.13	35.32	70.64	105.96	141.28	176.60	211.92
43	14.97	37.43	74.86	112.28	149.71	187.14	224.57
44	15.86	39.64	79.28	118.92	158.56	198.20	237.84
45	16.83	42.08	84.16	126.24	168.33	210.41	252.49
46	17.97	44.92	89.84	134.76	179.68	224.60	269.51
47	19.19	47.99	95.97	143.96	191.94	239.93	287.91
48	20.49	51.22	102.44	153.66	204.88	256.09	307.31
49	21.84	54.60	109.20	163.79	218.39	272.99	327.59
50	23.29	58.23	116.45	174.68	232.91	291.13	349.36
51	24.80	62.00	124.00	186.01	248.01	310.01	372.01
52	26.42	66.05	132.09	198.14	264.19	330.24	396.28
53	28.09	70.22	140.44	210.65	280.87	351.09	421.31
54	29.83	74.58	149.15	223.73	298.30	372.88	447.46
55	31.66	79.14	158.29	237.43	316.57	395.71	474.86
56	34.14	85.35	170.71	256.06	341.42	426.77	512.13
57	36.80	92.00	184.01	276.01	368.02	460.02	552.03
58	39.55	98.86	197.73	296.59	395.45	494.31	593.18
59	42.45	106.14	212.27	318.41	424.55	530.69	636.82
60	45.49	113.72	227.45	341.17	454.90	568.62	682.35
61	49.45	123.63	247.27	370.90	494.53	618.16	741.80
62	53.54	133.85	267.71	401.56	535.41	669.26	803.12
63	57.91	144.78	289.56	434.35	579.13	723.91	868.69
64	62.39	155.98	311.96	467.94	623.93	779.91	935.89
65	67.14	167.85	335.69	503.54	671.39	839.24	1,007.08
66	74.72	186.79	373.59	560.38	747.17	933.96	1,120.76
67	82.66	206.65	413.31	619.96	826.62	1,033.27	1,239.93
68	91.02	227.56	455.12	682.67	910.23	1,137.79	1,365.35
69	99.84	249.61	499.21	748.82	998.43	1,248.03	1,497.64
70	109.18	272.95	545.89	818.84	1,091.79	1,364.74	1,637.68

Actual premiums may vary slightly due to administrative system rounding.
(*) Rider Keys: TI=Terminal Illness Accelerated Benefit: All ages, LTC75 RR50%=LTC Accelerated Benefit (excluding term riders) up to 25 months PLUS Extension of Benefits to 75 months, Restoration rider restores up to 50% of death benefits: Ages 18-70 (No EOB ages 71-80),

Initial death benefit is guaranteed to later of 25 years or age 70. After this period, death benefit is projected level to age 121. Guarantees are based upon 2.00% interest and guaranteed insurance charges. Non-guaranteed benefits include credits based upon 3.5% interest and current insurance charges. The Age Paid Up is the attained age where the initial base death benefit (excluding death benefit provided by term rider) is projected to be fully paid-up under current assumptions. The plan has no cash surrender or loan values. Underwritten by Combined Insurance Company of America.

Identity Theft Protection

PrivacyArmor offers consumers a comprehensive, proactive identity theft defense. Our proprietary technology makes InfoArmor's identity protection more than enough to help fight 21st century crime.

SNAPD2.0 Identity Monitoring

We monitor identities to uncover identity fraud at its inception. Now with High Risk Transaction alerts, more fraud is detected sooner, including unauthorized account access, fund transfers and password resets.

CreditArmor

CreditArmor offers an annual credit report, monthly credit scores, and monitoring of your TransUnion credit file for no additional charge. Activate these credit services in your online portal with our complements.

Internet Surveillance

By scouring an ever-evolving network of compromised machines, we detect information misuse and compromised credentials in the Underground Internet and alert consumers with unparalleled accuracy.

Digital Identity

This interactive, easy-to-read report summarizes what a real-time deep Internet search finds out about a subscriber, offers a Privacy Grade and tips to better secure personal information.

WalletArmor

This secure, online document repository makes lost wallet replacement quick and easy. Using state-of- the-art technology, we now include real-time card monitoring of the Underground Internet.

Social Media Reputation Monitoring - January, 2015

We monitor your Facebook, LinkedIn, Twitter, and Instagram profile to give actionable alerts of reputational damage including racist, violent, derogatory, vulgar, or inappropriate comments. Let us keep tabs on your digital footprint so you don't have to.

Privacy Advocate Remediation

Our Privacy Advocates are CITRMS® Certified and ITRC Trained to be experts in identity restoration. If we detect suspicious activity, a Privacy Advocate will act as a dedicated case manager to act on behalf of the victim and resolve the issue from start to case completion.

$1,000,000 Indentity Theft Insurance Policy

Protect consumers from the financial damages of identity theft with our $1,000,000 Identity Theft Insurance Policy* for associated costs, legal defense expenses, and lost wages

Solicitation Reduction

We reduce the root cause of up to 20% of identity theft by decreasing junk mail, stopping pre-approved credit offers, and ending telemarketing calls.

Identity Theft Protection Monthly Employee Premiums

Monthly Rate	ID Theft Protection
Employee Only	$7.96
Family	$13.96

INFOARMOR.
IDENTITY PROTECTION EXPERTS

Employee Assistance Program

The Employee Assistance Program (EAP) is a benefit provided to District employees and their family members to assist when personal or work-related problems emerge. Using the EAP does not cost you anything and is completely confidential. New Directions is available 24 hours, 7 days a week to help you find balance with:

- Marriage
- Children
- Stress
- Emotions
- Finances
- Legal
- Child Care
- Elder Care
- Healthy Lifestyle
- Personal Growth

NEW DIRECTIONS BEHAVIORAL HEALTH

To access the New Directions online services go to:

Website: www.ndbh.com, click on EAP Members
Login Code: Raytown SD

Raytown Schools Wellness Center

The Raytown Schools Wellness Center is free to all District employees, their spouses, and children under the age of 18 (children must be 13 or older to use the exercise floor). Registration to use the facility is required.

Registration includes:

- Fitness evaluations
- Program design
- Group exercise classes
- Various exercise equipment
- Indoor track
- Indoor pool
- Locker rooms
- Child care

The Raytown Schools Wellness is located at **10301 E 350 Highway, Raytown, MO 64138** and is open the following hours[1]:

Day	Wellness Center	Pool Hours	Child Care
Monday	5:00 AM – 9:00 PM	5:15 AM – 8:00 PM	4:00 PM – 8:00 PM
Tuesday	5:00 AM – 9:00 PM	5:15 AM – 8:00 PM	4:00 PM – 8:00 PM
Wednesday	5:00 AM – 9:00 PM	5:15 AM – 8:00 PM	4:00 PM – 8:00 PM
Thursday	5:00 AM – 9:00 PM	5:15 AM – 8:00 PM	4:00 PM – 8:00 PM
Friday	5:00 AM – 8:00 PM	5:15 AM – 7:00 PM	Closed
Saturday	8:00 AM – 5:00 PM	8:15 AM – 4:00 PM	9:00 AM –1:00 PM
Sunday	10:00 AM – 5:00 PM	10:15 AM – 4:00 PM	Closed

[1] *The hours of operation are subject to change. If this occurs, changes that affect the established schedule will be communicated to employees.*

403b and 457 Plans

Raytown C-2 School District **does not** endorse investment products or vendors. The ultimate decision of where to invest rests with each individual participant. Included with this information is a list of authorized vendors and contact information for them.

Plan documents are available on www.raytownschools.org or District Intranet.

Forms To Complete:

- 403b/457/Roth Salary Reduction Election Agreement Access Link Online at www.tsacg.com/individual/plan-sponsor/missouri/raytown-c-2-school-district
- New Hires-Enrollment Forms will be provided by The Payroll department (New Hire Packet)

Explanation:

- As a benefit to its employees, the District provides a salary reduction option for purchase of tax sheltered investments/annuities in the form of a deferred compensation plan.
- The minimum salary reduction is $16.67 per month.
- Check with financial planner and/or tax accountant regarding these investment options.
- Once a 403b/457 Salary Reduction Agreement is filed, it continues from year to year until the employee files an amended form.
- The employee may start, stop, increase or decrease his/her salary reduction under the plan in any month except June, July and August.
- Salary Reduction Agreement must be filled out by the employee, signed by his/her agent, dated and submitted to the Payroll Office in the month prior to the month in which the deduction is taken.
- Participation in either retirement plan is voluntary and should be based on your financial objectives and resources. Individual investment strategies should reflect your personal savings goals and tolerance for financial risk. You may want to consult a tax advisor or financial planner before enrolling. Raytown C-2 School District is not liable for any loss that may result from your investment decisions.

As an employee of the Raytown C-2 School District you are eligible to participate in the District's 403(b) and 457 Deferred Compensation Plan. These plans allow you to save money on a pre-tax basis, and are designed to work in tandem with one another since the 457 and 403(b) limits do not have to be coordinated. Per IRS regulations, savings of $18,000 annually in each plan for combined total of $36,000 annually are possible. A nice feature of the 403(b) or 457 plans is that it allows you to make up for lost time. If you are within three years of retirement and you haven't made the maximum contributions every year, you may be able to make "CATCH-UP CONTRIBUTIONS." Please contact your financial advisor for details and to determine whether you qualify.

It's your future, invest in it!

For Additional Details Contact One
Of The Above Approved Representatives

Or

TSA Consulting Group, Inc.
Attention: Participant Transactions
28 Ferry Road SE
Fort Walton Beach, FL 32548
Telephone: 888-796-3786 • Fax: 888-742-0645

MO$T

Forms to Complete:

- Missouri Savings for Tuition Participation Agreement (one for each participant) *(see below link)*
- Missouri Savings for Tuition Authorization for Automatic Payroll Deduction *(see below link)*

Benefit Explanation

- MO$T is a flexible higher education savings program which is available to anyone, regardless of whether he or she is a resident of Missouri. Parents, grandparents, relatives and friends can open an account for a child. Employees can also open an account to use for themselves.
- The account can be used for qualified higher education expenses at any eligible educational institution in the country, as well as some schools abroad. Eligible schools include virtually all accredited colleges, universities, and two-year postsecondary institutions, and certain propriety or vocational/technical schools.
- Qualified expenses include tuition, fees, supplies, certain room and board costs, and books and equipment required for college enrollment or attendance.
- MO$T accounts have a low minimum contribution.
- MO$T operates under the direction and control of the Missouri Higher Education Savings Program Board.
- MO$T accounts are tax advantage to Missouri taxpayers. Missouri taxpayers can deduct up to $8,000 in contributions annually from their Missouri adjusted gross income. All earnings on contributions are exempt from Missouri state taxes if used for qualified higher education expenses of the designated beneficiary and are not subject to federal income tax until withdrawn.
- MO$T offers 2 investment options –a Guaranteed Option and a Managed Allocation Option.
- For more information, enrollment and salary reduction forms please visit the below website.
- Printed brochure.
- 1-888-414-MO$T (1-888-414-6678)

www.missourimost.org

MISSOURI'S 529 COLLEGE SAVINGS PLAN

Workers' Compensation Insurance

Form to Complete:

- Forms may be accessed on Raytown C-2 School District Intranet
- Worker's Compensation Employee's Injury Statement Form
- Worker's Compensation Treatment Authorization

Benefit Explanation:

- Missouri law and Raytown Consolidated School District No.2 School Board Policy guarantee certain benefits to employees who are injured or become ill because of their jobs.
- Any job related injury is covered, the key is whether it was caused by the job and the duties assigned to that job.
- Benefits include medical treatment and payment for lost wages if a job injury or illness temporarily disables the employee.
- When an injury occurs, the employee must report the injury IMMEDIATELY to a supervisor.
- The supervisor will complete the Treatment Authorization form and contact the District's Payroll department.
- Raytown School District requires that employees use the facilities of:

CareHere Clinic
10301 E. 350 Hwy
Raytown, MO 64138

- If seriously injured or after CareHere Clinic office hours below are authorized hospitals:

Research Hospital Emergency
2316 E. Meyer Blvd.
Kansas City, MO

St. Luke's East Emergency
100 NE Saint Luke's Blvd.
Lee's Summit, MO

For a detailed explanation see:

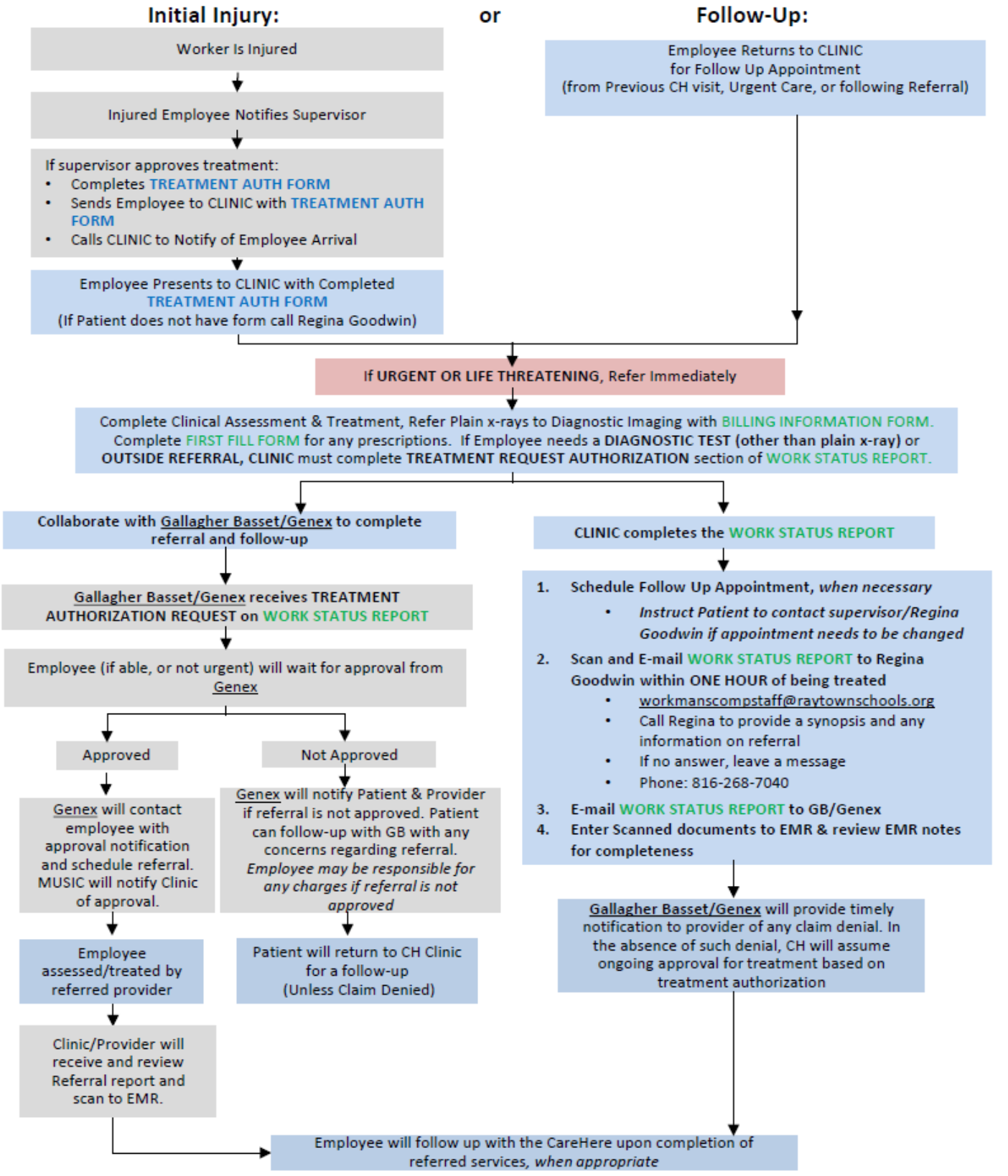
- Contact Regina Goodwin, Lead Benefit-Finance Specialist
  816-268-7040
  regina.goodwin@raytownschools.org
- Raytown School District Employee Handbook
- Raytown School District Board Policy
- Posters are located in each building for review

Missouri law and Raytown C-2 School District school board policy requires all employees to report any work related injury or illness to their immediate supervisor within 24 hours. All work related accidents or illnesses must be reported. The District is not liable for any doctor bills other than those through the above named services and their referrals. If the employee chooses to go to his or her doctor rather than the designated provider, the medical expenses will be charged to the employee. The employee must use the District's workers' compensation doctors and referral process.

CareHere!

RAYTOWN SCHOOLS QUALITY CARE CLINIC

WORKERS' COMPENSATION PROCESS FLOW



Updated: 3.19.2018

Professional Liability Insurance

Form to Complete:

- None

Benefit Explanation:

- Professional Liability Insurance coverage is provided by the Raytown School District Board of Education at no cost to the employee for all staff members with a maximum coverage of $2,000,000. The coverage is automatic to the employee and no application forms are necessary.

Unemployment Insurance

Form to Complete:

- None

Benefit Explanation:

- All employees of the Raytown School District are covered by unemployment insurance. Raytown School District is insured and reimburses the state for claims for which the District is ruled liable.
- Federal posters are located in each building for review.

Retirement System of Missouri

PSRS - Certified Teachers / PEERS - Non-Teacher-Classified Personnel

Form(s) to Complete:

Membership Record Based on Certification (PSRS) or Classified (PEERS) Eligibility Forms provided by the Payroll department (New Hire Packet)

Benefit Explanation:

- PSRS and PEERS is a defined benefit plan that provides disability and service retirement benefit to members and survivor benefits to qualified beneficiaries.
- Membership in PSRS is **mandatory** for certified staff working at least 17 hours per week on a regular basis and Membership in PEERS is **mandatory** for classified staff working at least 20 hours per week on a regular basis for an employer included in the retirement system.
- A **Certified** employee contributes 14.5% of gross wages and health benefit and the Board of Education contributes 14.5% for a total of an annual 29% to The Public School Retirement System. A **Classified** employee contributes 6.86% of gross wages and health benefit and the Board of Education contributes 6.86% for a total of an annual 13.72% to the Non-Teacher Public School Retirement System.
- A **PSRS** member who is required to contribute to Social Security will have a contribution rate of 9.67% (two third's the normal PSRS contribution rate as required by statute).

Position	Withholding Method Required Beginning July 1, 2010
Full-time Teachers who are PSRS members. Exception: see Critical Shortage Hires and Rehired Annuitants below.	No Social Security
Part-time teachers 20 or more hours per week but less than full-time on a regular basis.	PEERS members No Social Security PSRS No Social Security
Part-time teachers 17 or more hours but less than 20 hours per week on a regular basis that are NOT Rehired Annuitants.	No Social Security
Part-time teachers working less than 17 hours per week that are NOT Rehired Annuitants.	Social Security
Certificated teachers working full-time in non-teaching position.	Social Security
Certificated teachers working part-time in non-teaching position.	Social Security
Rehired Annuitants and Critical Shortage Hires	Social Security
Non-certificated personnel working in non-teacher positions.	Social Security

The Public School Retirement System of Missouri
PO Box 268 · 701 West Main · Jefferson City, MO 65102 Telephone: 573-634-5290 Toll Free 800-392-6848
Email: member_services@psrsmo.org · Web site: http://www.psrs-peers.org

Social Security Information

Forms To Complete:

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security Forms provided by the Payroll department (New Hire Packet)

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security Web site, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer.

Payroll Information

See Raytown C-2 School District Web Link to Forms or Government Links: www.raytownschools.org

Income Tax Withholding—W4

Form to Complete:

- Federal W-4 (HR New Hire Packet) Talent Ed Records
- MO W-4 (HR New Hire Packet) Talent Ed Records

Explanation:

These forms allow the District to withhold the correct Federal and State income tax. Raytown C-2 School District personnel are not tax advisors and will only provide government contact information for questions regarding completion. Please see your tax advisor for additional information.

Kansas City Earnings Tax: Persons living or working in Kansas City Missouri are subject to the 1% Kansas City Earnings Tax withholding.

Direct Deposit Authorization

Forms to Complete

- Direct Deposit Authorization Form (HR New Hire Packet) Talent Ed Records

Explanation:

This form authorizes the District to deposit and reverse payroll wages into no more than two accounts at your financial institution(s). All employees are **required to complete a form**. This form must be received by the 10th of the month to payroll. A voided check or banking letter must be attached for verification.

Glossary

Deductible

The deductible is the amount of your covered expenses you must pay each calendar year before the insurance company begins to pay. The individual deductible is the amount each covered family member must pay before the insurance company begins to pay. However, every dollar applied to the individual deductible will also be applied to the family deductible. Once the family deductible is met, the plan will pay benefits for all family members.

Coinsurance

After the deductible is met, you and the insurance company share in the payment of your medical bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers are utilized.

Covered Expenses

Covered expenses are the expenses that are eligible for reimbursement. All of the medical coverage options generally provide benefits for medically necessary services and supplies ordered by a doctor for the treatment of an accidental injury, sickness or pregnancy. Each option also provides benefits for certain routine and preventive services. Under all plans, when benefits are paid for out-of-network covered expenses, the insurance company will consider payment of those expenses only up to Reasonable and Customary (R&C) limits.

Copayment

Copayment refers to a fixed cost that you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician and pharmacy).

In-Network

In-network coverage is provided for covered expenses when you receive treatment or services from a provider or hospital which is a member of the insurance company plan provider network. In-network coverage is the highest level of coverage provided.

Out-of-Network

Out-of-Network coverage is provided for covered expenses incurred when you receive treatment or services from a provider or hospital which is not a member of the insurance company plan provider network. The plan considers covered expenses only up to Reasonable and Customary (R&C).

Out-of-Pocket Maximum

This maximum limits your out-of-pocket expenses (including deductibles, medical and Rx copayments, and coinsurance) in any one calendar year. If you reach the individual out-of-pocket maximum for any covered family member, the plan pays 100% of that person's covered expenses for the remainder of the year. If you reach the family out-of-pocket maximum, the plan pays 100% of your entire family's covered expenses for the remainder of the year. Please note that any prescription drug copayments as well as expenses not covered by the plan do not count towards the out-of-pocket maximum and remain the participant’s responsibility to pay even after the out-of-pocket maximum is reached.

Reasonable and Customary

The insurance company plans will not pay for any charge above Reasonable and Customary (R&C) limit when you receive services from out-of-network providers, and these charges do not count towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services & supplies in your geographic area. The insurance company determines whether or not a charge is reasonable and customary and keeps up-to-date with the latest medical practices and fees around the country. Because in-network providers and hospitals provide services and supplies for agreed-upon rates, you will never exceed R&C charges when you use in-network providers.

Annual Notices

HIPAA Privacy Notice – Notice of Privacy Practices

Notice of Privacy Practices

The Raytown C-2 School District 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.

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. This notice applies to the Raytown C-2 School District. If you would like to pursue any of your individual rights regarding your PHI, contact Payroll Department, Raytown Quality Schools, 6608 Raytown Road, Raytown, MO 64133. You have the right to contact U.S. Department of Health and Human Services' Office for Civil Rights (OCR) if you have any complaints about how the Plan has handled your PHI. You can submit your complaint online, or download a complaint form at this OCR website (http://cms.hhs.gov/hipaa). Or, you can send your complaint or question to this e-mail address: askhipaa@cms.hhs.gov. Or, you can call the CMS HIPAA Hotline: 1-866-282-0659. This notice becomes effective on April 14, 2003.

COBRA – Initial (General) COBRA Notice Continuation Coverage Rights under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Raytown C-2 School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Payroll Department, Raytown Quality Schools, 6608 Raytown Road, Raytown, Missouri 64133. A written notice is required as well as proof of the qualifying event.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
You must provide proof of disability to the Plan Administrator (i.e. letter of determination from the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Payroll Department
Raytown Quality Schools
6608 Raytown Road
Raytown, Missouri 64133

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 (depending on your carrier plan document) 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.

Woman's Health and Cancer Rights Act (WHCRA) of 1998

Your plan, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact your Plan Administrator for more information, 816-268-7000.

Medicare Part D Notice – Medicare Part D Notice for Base PPO, Buy-Up PPO and Qualified High Deductible PPO Plan Participants – Important Notice from Raytown School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Raytown C-2 School District 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. Raytown C-2 School District has determined that the prescription drug coverage offered by the Raytown C-2 School District Medical 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 Raytown C-2 School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Raytown C-2 School District coverage, be aware that you and your dependents may be able to get this coverage back provided you are a benefits eligible employee.

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 Raytown C-2 School 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 Raytown C-2 School 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: July 1, 2018
Name of Entity/Sender: Raytown C-2 School District
Contact--Position/Office: Payroll Department
Address: Raytown Quality Schools, 6608 Raytown Road, Raytown, Missouri 64133
Phone: 816-268-7000

Lifetime limit

The lifetime limit on the dollar value of benefits under your group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Payroll Department, Raytown Quality Schools, 6608 Raytown Road, Raytown, MO 64133 or call 816-268-7000.

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, 2018. 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: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
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: 1-800-862-4840	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: https://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://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.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://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
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, 2018, 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

Raytown Quality Schools' wellness incentive program is voluntary and available to all employees, covered on the health plan. 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 the following voluntary health activities through Raytown Quality Schools Quality Care Clinic, CareHere: Health Questionnaire or Health Risk Assessment (HRA) that asks a series of questions about your health-related activities and behaviors including your Tobacco/Nicotine Status 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 Blood pressure and BMI and a blood test for Total Cholesterol, LDL Cholesterol Calc, HDL Cholesterol, T. Chol/HDL Ratio, Triglycerides, Sodium Serum, Potassium Serum, Chloride, Carbon Dioxide, Blood Urea Nitrogen, Creatinine, BUN/Creatinine Ratio, Glucose, Serum, Calcium, Phosphorus Serum, Magnesium Serum, Aspartate Aminotransferase Enzyme, Alanine Aminotransferase Enzyme, Gamma Glutamyl transferase Enzyme, Bilirubin – Total, Alkaline Phosphatase Serum, Lactate Dehydrogenase Enzyme, Protein Total Serum, Globulin Total, Iron Serum, Uric Acid Serum and achieve the following biometric benchmarks or complete a reasonable alternative*:

- Total Cholesterol or TC to HDL Ratio: Total Cholesterol < 200 or TC/HDL ratio of < 4
- Fasting Blood Sugar (Glucose): 109 or less
- BMI (Body Mass Index) or Waist Circumference: < 27 BMI or Waist Measurement < 40 inches (males) and < 35 inches (females)
- Blood Pressure: Systolic: 140 or less; Diastolic: 90 or less (measurements listed individually)
- Tobacco/Nicotine Status: Non-Tobacco/Nicotine User (Registration Questionnaire Reported)

* If your biometric screening results are out of the benchmark ranges listed above, and/or you are a tobacco user, you can still earn the wellbeing incentive by scheduling and attending a "HRA Follow-up" appointment with the Raytown Schools Quality Care Clinic provider to review your HRA results and get enrolled in a CareHere Wellness Plan or work with your personal physician.

You are not required to complete the HRA or to participate in the blood test or other medical examinations, or meet the biometric benchmarks (or complete the reasonable alternative); however, employees who choose to participate will save $35 a month on their health plan premium.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you are entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Michelle Kruse at mkruse@cbiz.com.

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 health coaching. 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 Raytown Quality Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, CareHere 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) Clinic Providers/Staff and Certified Health Coaches 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:

Dr. Marlene Devilbiss, Assistant Superintendent of Human Resources
Raytown Quality Schools
6608 Raytown Road
Raytown, Missouri 64133
Phone: 816-268-7000.

Notes

Notes