Raytown C-2 School District

2016 Employee Benefits Guide

Plan Year Begins July 1, 2016

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
- Raytown Schools Wellness Center
- Tri-Star Systems Flexible Spending Accounts
- Trustmark Accident, Critical Illness and Cancer Plans

Feeling Secure

- The Standard Group Term Life
- 403b and 457 Retirement Plans
- Section 529 MO$T Missouri Savings for Tuition

Work/Life Balance

- New Directions Behavioral Health Employee Assistance Program (EAP)

CONTENTS

CONTACT INFORMATION

Medical
BlueKC
866-228-0556
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

Accident, Critical Illness, Cancer, Short Term Disability, Permanent Life with LTC
Worksite Benefit Associates
913-353-1300
kthayer@wksite.com

403b and 457 Plans
ASPire Financial Services
866-634-5873
www.aspireonline.com

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

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

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

Workers' Compensation
CareHere Clinic
877-423-1330

Health Savings Accounts
UMB
866-520-4472
hsaresearch@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

Employee Assistance Program
New Directions Behavioral Health
800-624.5544
www.ndbh.com

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

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

VALIC
913-402-5000
www.valic.com

PSRS/PEERS
Missouri Retirement Systems
800-392-6848
www.psrs-ntrs.org

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

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.

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. Spouses and dependent children to the end of the month in which they reach age 26 are eligible for coverage as well.

If you work a minimum of 20 hours per week, you are eligible to enroll in accident insurance, critical illness and term life as described in this guide. Spouses and dependent children to the end of the month in which they reach age 26 are eligible for coverage as well.

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 Human Resources 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 Human Resources 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 Human Resources department if you have a qualifying event.

When to Enroll

- Certified staff are eligible for benefits the first of the month following the first paycheck.
- 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 contact Human Resources department 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
- Critical Illness Plan
- Cancer Insurance Plan
- Short Term Disability
- Permanent Life with Long Term Care
- 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 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 and pro-rated 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:

- $595.27 District Paid for Employees working 30 hours or more per week that elect either the $1000, $1500 or $2500 Deductible plan
- $645.27 District Paid for Employees working 30 hours or more per week that elect the BlueSaver QHDHP plan.

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.

BlueKC Plans Employee Costs

	$1000 PPO Buy-Up	$1500 PPO Buy-Up	$2500 PPO Base	BlueSaver QHDHP
Employee Working 30 hours or more				
Employee Only	$174.15	$131.51	$50.00	$0.00
Employee/Spouse	$1,174.27	$1,076.24	$888.74	$838.74
Employee/Children	$843.52	$763.84	$611.39	$561.39
Family	$1,828.30	$1,694.01	$1,437.22	$1,387.22

BlueKC 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	 $2,600 $5,200
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 now includes <u>all</u> copays (medical and prescription drug copays).*

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 prescribing of prescription drugs, and greater occurrence of "lifestyle-related" conditions, the savings once achieved through tightly managing health care delivery has been outpaced by inflation and rejected by consumers who demand more freedom. There are two parts to this plan. The medical plan (QHDHP) and the banking piece (HSA).

Part one, the QHDHP, will have a $2,600 Individual/$5,200 Family Deductible. Every service, including prescription drugs, will go toward the Deductible. Once you have satisfied the Out of Pocket Maximum amount, all medical services will be paid at 100% for the remainder of the plan year.

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

Who is eligible to participate in a HSA?

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

You are ineligible if you and/or your spouse are contributing to a Section 125 FSA plan that is not a LIMITED FSA. 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 2016 calendar year is $3,350 for individual coverage and $6,750 for family coverage. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

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.

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 an HSA account and later enroll in a non-qualified plan, you will no longer be able to contribute to the HSA, but your account will continue to accumulate interest. You may also withdraw from the account for qualified 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 an HSA during enrollment. Second, you must complete the District supplied Payroll Deduction Form and return the form to the District's Human Resources department.

For additional information please contact UMB Healthcare Services at UMB Bank at 866-520-4472 or hsaresearch@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

Who Can Use the Clinic?

Benefit enrolled employees, dependents, and pre-Medicare retirees of Raytown Quality Schools over the age of 2 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 manager 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:

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

Wellness Services Provided By
- Registered Dietitian
- Registered Nurse
- Behavioral Health Coach
- Tobacco Cessation Coach
- Exercise Physiologist

Sports / Camp / School Physicals

Referral to Specialists

Coordination with Outside Providers

Worker's Compensation and Occupational Health

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 Hours	Nurse Only Hours[2]	Worker's Compensation / Occupational Health Hours
Monday	7:00 AM – 11:00 AM, 12:00 PM – 4:00 PM	-	-
Tuesday	1:00 PM – 6:00 PM	7:00 AM – 8:00 AM	8:00 AM – 12:00 PM
Wednesday	7:00 AM – 11:00 AM, 12:00 PM – 4:00 PM	7:00 AM – 12:00 PM	-
Thursday	12:00 PM – 6:00 PM	7:00 AM – 8:00 AM	8:00 AM – 12:00 PM
Friday	7:00 AM – 11:00 AM	7:00 AM – 11:00 AM	-
Saturday	Closed	Closed	Closed
Sunday	Closed	Closed	Closed

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

[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:

	Non-Preventive		Preventive	
Medical Plan	**Visit or Lab Work**	**Rx**	**Visit or Lab Work**	**Rx**
$1,000, $1,500 or $2,000 Preferred-Care Blue Plans	**Free**	**Free**	**Free**	**Free**
Preferred-Care Blue HSA Blue Saver Plan QHDHP *(Qualified High Deductible Health Plan)*	**$30**, until deductible is met[3,4]	**$8** per Medication[3]	**Free**	**Free**

[3] Fee applies towards deductible and out of pocket maximum.

[4] 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.

We want you to be prepared that the visit fee will be collected upon arrival for each appointment if you are on the Preferred-Care Blue HSA Blue Saver Plan being seen for non-preventive care. 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 $1,000, $1,500 or $2,000 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 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 7/1/2015.

2 Delta Dental will continue providing benefits for orthodontic treatment plans that were covered by the prior carrier and in progress on 7/1/2015. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.

Delta Dental Dental Plans Employee Costs

	Dental Low Plan	Dental High Plan
Employee Only Employee Plus 1 Dependent Employee Plus 2 or More Dependents	$20.28 $38.65 $66.05	$36.56 $70.68 $110.39

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
- Contacts	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
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 Employee Costs

	VSP Vision Plan
Employee Only	$8.48
Employee Plus 1 Dependent	$16.96
Employee Plus Children	$18.14
Family	$29.00

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, 2016 through June 30, 2017***. 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 $2,550.

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.

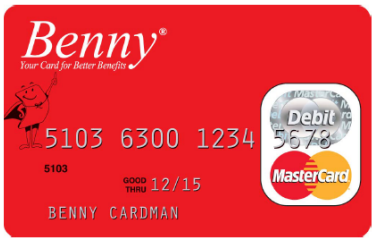
If you experience a "qualifying change in status event", and you wish to modify your benefit selections, you must notify the Human Resources department within 30 days of the change.

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.

New this Year: 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: You may purchase coverage in units of $10,000 to a maximum of $200,000 without medical questions. Coverage over these amounts 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 $25,000 without medical questions. Coverage over these amounts to a maximum of $250,000 is available with medical questions. 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.

Supplemental Term Life with AD&D Employee Costs

Employee Coverage

Employee's Age *As of July 1, 2016*	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, 2016*	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

Trustmark Accident Insurance provides supplemental coverage to cover the costs resulting from covered accidental injuries or death. You may choose to provide coverage for yourself and eligible family members. Benefits include, but are not limited to:

- Hospital Admission
- Hospital Confinement
- Hospital Intensive Care Unit
- Accidental Death
- Catastrophic Accident
- Health Screening

Trustmark Companies
PERSONAL. FLEXIBLE. TRUSTED.

Accident Insurance Employee Costs

Monthly Rate	Hospital Plan 5
Employee Only	$17.92
Employee and Spouse	$26.78
Employee and Child(ren)	$33.74
Family	$42.60

Critical Illness Plan

Trustmark Critical Illness plan pays a lump sum to covered employees upon the diagnosis of a covered critical illness which may include heart attack, stroke, end stage renal disease and more. Coverage is available on eligible family members as well. For more information please contact Worksite Benefit Associates at 913-353-1325 or jcastillo@wksite.com.

Cancer Insurance - *New for 2016*

Transamerica Cancer Insurance is based on a schedule of benefits. A policy holder is paid based on the services perform while under the treatment for cancer. Some examples of when payment would be received are: surgery, radiation, chemotherapy, bone marrow and many more. These payments are not offset by other insurance policies. For more information please contact Worksite Benefit Associates at 913-353-1300 or kthayer@wksite.com.

TRANSAMERICA

Cancer Insurance Employee Costs

Monthly Rate	Plan 1 (Low Plan)	Plan 2 (High Plan)
Employee Only	$20.79	$32.18
Employee and Child(ren)	$23.92	$36.97
Family	$38.02	$58.69

Short Term Disability

Trustmark 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.

- Benefits are payable for total and continuous disability due to a covered non-occupational injury or accident.
- Benefits are paid in the same frequency as your paycheck.
- You may elect coverage amounts up to 60% of income, up to $6,000 monthly (medical questionnaire and underwriting may be required).
- Employees are eligible for short-term coverage with a 7-day elimination period for disabilities from sickness and accident, and a maximum duration of 6 months.
- Coverage is portable and Waiver of Premium is included.

Covered Maternity Benefits, a pregnancy is covered the same as sickness when it begins after your coverage has been in effect for a period of 10 months.

Pre-existing Conditions, generally, if you become disabled because of a pre-existing condition, the disability is not covered if it begins during the first 12 months after the plan's effective date. Pre-existing condition means a sickness or physical condition for which you were treated, received medical advice or had taken medicine within 12 months before the effective date.

Permanent Life with Long Term Care

Trustmark's Universal LifeEvents Insurance provides a death benefit to your beneficiaries if you pass away, but also builds cash value and features living benefits for long-term care. It pays a higher death benefit during your working years when expenses are high and you need maximum protection. Then, at age 70 when your financial needs are lower, your death benefit reduces to one-third.

OPTIONAL BENEFITS

- Long Term Care Benefit (LTC) pays 4% of your death benefit for up to 25 months for home healthcare, assisted living, nursing home care and adult day care. There is a 90-day elimination period before benefit can be paid. To receive benefits you must meet Conditions of Eligibility for Benefits. The LTC benefit does not reduce at age 70.
- Benefit Restoration restores the death benefit1 that is reduced to pay for LTC, so your family receives the full death benefit amount when they need it most.
- EZ Value automatic increases.

Trustmark Companies

PERSONAL. FLEXIBLE. TRUSTED.

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 Human Resources (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

MOST
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 Benefit Office or Human Resources.
- 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 Julie Grimmett, Lead Benefit-Finance Specialist
  816-268-7067
  julie.grimmett@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
WORKER'S COMPENSATION PROCESS FLOW

Initial Injury:

Worker Is Injured

↓

Injured Employee Notifies Supervisor

↓

If supervisor approves treatment:
- Completes **TREATMENT AUTH FORM**
- Sends Employee to CLINIC with **TREATMENT AUTH FORM**
- Calls CLINIC to Notify of Employee Arrival

↓

Employee Presents to CLINIC with Completed **TREATMENT AUTH FORM**

or

Follow-Up:

Employee Returns to CLINIC for Follow Up Appointment

↓

CLINIC completes the WORK STATUS REPORT

- If **URGENT OR LIFE THREATENING**, Refer Immediately
- If Employee needs a **DIAGNOSTIC TEST or OUTSIDE REFERRAL, CLINIC must complete TREATMENT REQUEST AUTHORIZATION section** of **WORK STATUS REPORT and provide referral location to Employee at this time**

1. **Schedule Follow Up Appointment, *when necessary***
2. **Scan and Email WORK STATUS REPORT to Julie Grimmett within ONE HOUR of being treated**
   - julie.grimmett@raytownschools.org
   - Call Julie to provide a synopsis and any information on referral
   - If no answer, leave a message
   - Phone: 816-268-7067
3. **Fax WORK STATUS REPORT to RTW (952) 893-3700**

If Diagnostic Test or Outside Referral was requested:

RTW receives TREATMENT AUTHORIZATION REQUEST on WORK STATUS REPORT

Employee (if able, or not urgent) will wait for approval from RTW

Approved	Not Approved
RTW will contact employee with approval notification	RTW will contact employee on Non-Approval Status *Employee may be responsible for any charges*

↓

Employee goes to referral location given by CLINIC provider during initial visit

↓

Employee will follow up with the CLINIC, *when appropriate*

Updated 12/28/2015

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 Human Resources (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% 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% 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 Human Resources (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 to be Used by Health Plans Subject to the HIPAA Privacy Rules

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.

Permitted Disclosures

The Plan can use and disclose your PHI for the following purposes, without your authorization, for making or obtaining payment for your health care, and for conducting health plan operations.

Examples of when and how your PHI can be used and disclosed for payment purposes, without your authorization, are:

- For coordination of benefits among multiple plans that cover you
- For utilization review purposes
- For case management purposes
- For precertification purposes
- Any other purpose necessary to ensure coverage for you, and to obtain or make payment for services rendered to you.

Examples of when and how your PHI can be used and disclosed for health plan operations, without your authorization, are:

- To ensure coverage for you
- For quality assessment purposes
- For cost containment purposes
- To ensure compliance with the terms of the Plan, or with clinical or other relevant medical guidelines and protocols
- To provide you with treatment alternatives
- For health plan and provider accreditation verification, licensure, or any other credentialing purposes
- For underwriting, premium rating, and related functions
- To create, renew, or replace your health insurance or health benefits
- To conduct audits, including compliance, medical, legal, business planning, cost containment, or customer service audit functions.

The Plan can share your PHI with the plan sponsor for certain administrative activities, without your authorization. Examples of sharing PHI include, but are not limited to:

- Seeking premium bids for current or future coverage
- Obtaining reinsurance
- Amending, modifying, or terminating the plan
- Participant and enrollment information

Your PHI can be released in summary form, or, as a part of "de-identified" information, in accordance with the Code of Federal Regulations. Other instances, in which your PHI may be released, without your authorization, include:

- When legally required by federal, state, or local law. This instance would include the release of PHI upon the receipt of an order, subpoena, or other judicial or administrative process that would compel the disclosure of your PHI. However, your PHI would only be disclosed after a reasonable effort has been made to notify you of the request for such information.
- For law enforcement purposes, such as investigation of a crime.
- To respond to a threat to public health or safety.
- For workers compensation purposes, or other no fault law.
- To a government authority, such as a social service or other protected services organization, authorized to receive reports of abuse, neglect, or domestic violence.

Authorization for Use and Disclosure

Except as provided above, the Plan will not release any of your PHI without your authorization. If you authorize the release of some, or all of your PHI, you may revoke the authorization at any time. If you authorize release of your PHI, your authorization must include the following items:

1. A description of information used or disclosed
2. Identification of the parties releasing, and the parties requesting the information
3. An expiration date of the authorization
4. Your signature
5. Information about how to revoke the authorization

Your Individual Rights

You have certain individual rights regarding your PHI; specifically:

1. If the Plan maintains your PHI, you have the right to inspect and request a copy it. The plan may charge a reasonable fee for copying this information. If the Plan does not maintain the PHI, which is the subject of your request, you will be directed to the appropriate party who can assist you with your inquiry.
2. You have the right to restrict the use and disclosure of your PHI, although the Plan is not required to agree with your request.
3. You have the right to receive confidential communications. You have the right to limit or restrict where, or how, the Plan may contact you regarding your PHI.
4. You have the right to request amendments or modifications to your PHI. If you believe your PHI is inaccurate or incomplete, you have the right to request an amendment to your records. In order to be entitled to amend the records, the Plan must maintain the relevant records, and you must make the request for amendment in writing. The Plan has the right to deny your request to amend or modify your PHI if:
   - You do not have a substantive reason for the request
   - The relevant records were not created by the Plan
   - The request falls within an exception to the amendment rights provided by the law
   - It is determined that the information is complete or accurate
5. You have the right to obtain an accounting of any disclosure that has been made of your PHI, other than those disclosures made for health care payment, treatment, or other health care plan operations. To exercise this right, contact Human Resources, Raytown Quality Schools, 6608 Raytown Road, Raytown, Missouri 64133.

If you would like to pursue any of your individual rights regarding your PHI, contact Human Resources, Raytown Quality Schools, 6608 Raytown Road, Raytown, Missouri 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 on-line, 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: Human Resources, 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.

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

Human Resources
Raytown Quality Schools
6608 Raytown Road
Raytown, Missouri 64133

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.

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, 2016
Name of Entity/Sender: Raytown C-2 School District
Contact--Position/Office: Human Resources
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.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are 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 are not 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 are not 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. Contact your State for more information on eligibility –

KANSAS – Medicaid

Website:
http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notes