2023
EAST BUCHANAN C-1 SCHOOL DISTRICT
EMPLOYEE BENEFITS GUIDE

2023 BENEFITS OVERVIEW

WELCOME TO THE 2023 BENEFITS OPEN ENROLLMENT

The East Buchanan C-1 School District annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the East Buchanan C-1 School District family and look forward to a healthy and safe year.

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Outside of Open Enrollment, you may not make any changes to your plans without a Qualifying Life Event (QLE) which grants you a special enrollment period. If you experience a QLE, you only have 30 days to notify HR that you would like to make a change to your benefits.

Some common QLE's include:

- ✔ You experience an involuntary loss of coverage
- ✔ Your employment or your spouse's employment terminates
- ✔ The hours you or your spouse work are reduced
- ✔ Birth, Adoption, Guardianship
- ✔ Marriage, divorce, annulment or legal separation
- ✔ Death of the employee, spouse or eligible dependent

TIP REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

IMPORTANT DATES

Open enrollment runs

May 20, 2023 –

June 9, 2023

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CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Blue KC, USAble Life, Nodaway Valley Bank, your East Buchanan C-1 School District Benefits Representative, or our CBIZ representative listed below.

MEDICAL INSURANCE

Blue KC
www.bluekc.com
888-989-8842

BASIC LIFE/AD&D & DEPENDENT LIFE INSURANCE

USAble Life
https://www.usablelife.com/
800-370-5856

HEALTH SAVINGS ACCOUNT

Nodaway Valley Bank
www.nvb.com
877-217-4682

BENEFITS REPRESENTATIVE

East Buchanan C-1 School District
Beth Carr
carr@ebs.k12.mo.us
816-424-6466

CBIZ REPRESENTATIVE

Andy Burnham
aburnham@cbiz.com
816-901-0906

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of East Buchanan C-1 School District, you have the choice between **three** medical plan options with Blue KC. Your options are a PPO plan (PCB $4,000 PPO (PPO Plan)), and two HSA plans (PCB $5,000 (Base Plan) & PCB $3,000 HSA (Buy-Up Plan)).

For all, your deductible will run from JANUARY 1 – DECEMBER 31.

All of the plans are a part of the broad Preferred-Care Blue (PCB) network, which gives you the option of going in or out-of-network, however, you will see the greatest savings when utilizing providers that are in-network because Blue KC has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Blue KC's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance. *When traveling outside of the Kansas City area, you will have access to the national BlueCard Network.*

Both the PCB $5,000 HSA (Base Plan) and the PCB $3,000 HSA (Buy-Up Plan) allow you to establish a Health Savings Account (HSA) with Nodaway Valley Bank, and if you enroll in the PCB $5,000 HSA (Base Plan) East Buchanan C-1 School District will contribute $62.50 per month into your HAS Account! These funds can be used to cover medical expenses, including deductibles, and they're yours forever — even if you leave East Buchanan C-1 School District. And unlike a Flexible Spending Account (FSA), they are not forfeited at the end of each year.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are electing medical coverage for the first time, changing plans, or adding any dependents.

? Does the deductible run on a calendar year or policy year basis?

A calendar year basis.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the year in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the first of the month following date of hire for regular full-time employees.

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- PCB $4,000 PPO (PPO PLAN)
- PCB $5,000 HSA (BASE PLAN)
- PCB $3,000 HSA (BUY-UP PLAN)

HOW TO FIND A PROVIDER

To find a Blue KC Medical Provider in your area, visit the website at www.bluekc.com.

- Click the **"Find Care"** from the top toolbar
- Under **"Continue As a Guest"** click **"Find Care as a Guest"**
- Click **"I Have or Might Get a Blue KC Health Plan Through my Employer"**
- Click the dropdown titled **"Select a Medical Network"** then select **"Preferred-Care Blue (PCB)"** then click **"Find Care as a Guest"**
- Make sure your location is correct or enter your ZIP Code in the top right-hand corner
- Enter what you are looking for into the search bar (ex: primary care)
- Scroll down & select a provider from the list

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.bluekc.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

BLUE KC VIRTUAL CARE

- Cold/flu
- Vomiting
- Fever
- Rash
- Sinus problems

Blue KC Virtual Care lets you see and talk to a doctor from your mobile device or computer without an appointment to bring you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS Caremark, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

MEDICAL INSURANCE

BLUE KC MEDICAL	PCB $4,000 PPO (PPO Plan)	PCB $5,000 HSA* (Base Plan)	PCB $2,800 HSA (Buy-Up Plan)
Employee Cost Per Month			
Employee	$28.52	$0.00	$28.52
Employee + Spouse	$1,059.54	$830.33	$1,059.54
Employee + Child(ren)	$659.88	$483.63	$659.88
Employee + Family	$1,290.41	$1,030.58	$1,290.41
Calendar Year Deductible (1)			
Individual / Family	$4,000 / $8,000	$5,000 / $10,000	$3,000 / $6,000
Coinsurance	0%	10%	0%
Maximum Out-of-Pocket (2)			
Individual / Family	$4,000 / $8,000	$6,450 / $12,900	$3,000 / $6,000
Physician Office Visits			
Primary Care Visits	$40 copay	Deductible then 10%	Deductible
Specialist Visits	$40 copay	Deductible then 10%	Deductible
Diagnostic Lab	$0 copay	Deductible then 10%	Deductible
Diagnostic X-Ray	Deductible	Deductible then 10%	Deductible
Urgent Care	$40 copay	Deductible then 10%	Deductible
Blue KC Virtual Visits (Sick / Behavioral Health)	$10 copay	Deductible then $10 copay	Deductible
Hospital Services			
Inpatient Care (Facility / Physician)	Deductible	Deductible then 10%	Deductible
Outpatient Surgery	Deductible	Deductible then 10%	Deductible
Imaging (CT/PET Scans, MRIs)	Deductible	Deductible then 10%	Deductible
Emergency Room	Deductible	Deductible then 10%	Deductible
Prescription Drugs			
Deductible	Does Not Apply	Applies, then:	Applies, then:
Tier 1 / 2 / 3 / 4	$15 / $70 / $110 / $200	10% coinsurance	0% coinsurance
Out-of-Network (3)			
Deductible - Individual / Family	$4,000 / $8,000	$5,000 / $10,000	$3,000 / $6,000
Coinsurance	20%	30%	20%
Maximum Out-of-Pocket - Individual / Family	$8,000 / $16,000	$12,900 / $25,800	$6,000 / $12,000

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

If you enroll in the PCB $5,000 HSA (Base Plan), East Buchanan C-1 School District will contribute $62.50 per month into your HSA Account!

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

All plans are detailed in Blue KC's 2023 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

BLUE KC VIRTUAL CARE

INTRODUCING BLUE KC VIRTUAL CARE

Blue KC members have affordable access to 24/7 healthcare. Blue KC Virtual Care Blue KC Virtual Care brings you care from the comfort and convenience of your home or wherever you are.

Blue KC Virtual Care is convenient for everyday medical health care needs such as the following:

URGENT/SICK CARE*

- sinus pain
- mild asthma
- mild allergic reactions
- minor headaches
- cold sores
- sprains
- pink eye
- nausea
- vomiting
- bumps
- cuts
- scrapes
- coughs
- sore throat
- eye irritation
- minor fever
- colds
- rashes
- minor burns

**Visits are $59 or less, depending on your plan.*

BEHAVIORAL HEALTH CARE*

In addition to sick care, members can now schedule a video visit with behavioral health therapists right from their smartphone, tablet or computer starting at $85 per visit. Blue KC Virtual Care is convenient for everyday behavioral health care needs such as the following:

- anxiety
- bereavement/grief
- bipolar disorder
- depression
- OCD
- PTSD/trauma
- panic attacks

**Therapy services are provided by a network of doctoral level psychologists and master's degree level therapists trained and licensed in virtual care prevention and therapy techniques.*

Always private, secure and affordably priced, members can register now at www.bluekcvirtualcare.com or download the MyBlueKC Mobile App in the Apple App Store or in Google Play to access Blue KC Virtual Care.

Download on the App Store

GET IT ON Google Play

GET STARTED TODAY WITH BLUE KC VIRTUAL CARE!

STEP 1: ACCESS

You can now access Blue KC Virtual Care from your MyBlueKC Mobile App which you can download in the Apple App Store or in Google Play. You can also visit www.bluekcvirtualcare.com from your desktop.

STEP 2: CREATE ACCOUNT

Create an account in a few simple steps. Be sure to use your Blue KC member ID card in order to input your insurance information.

STEP 3: DOCTOR SELECTION

View a list of available doctors, their experience and ratings, and select one.

STEP 4: VISIT

Request a visit when you are sick & stream a live visit directly from the Web or your mobile device.

BLUE KC NURSE LINE

NURSE LINE BENEFITS

Nurse Advisors are available 24 hours a day, seven days a week, 365 days a year to assist you with symptoms or answer a health-related question.

Just knowing these nurses are available to support you reduces stress and anxiety and gives you confidence in your health. No matter what the situation – from simple things like a twisted ankle, to an urgent care concern – the Blue Cross and Blue Shield of Kansas City (Blue KC) 24-Hour Nurse Line is there to help.

This 24-Hour Nurse Line is free to all Blue KC members.

HOW CAN WE HELP?

Here are just a few of the many other ways our Care Advisors can assist you:

- Convenient access to quality care
- Become better-informed about healthcare
- Gain confidence when speaking to providers during office visits
- Become educated on self-care for non-urgent injuries and illnesses
- Improve your knowledge of drugs and medications
- Live better with healthy lifestyle tips

Plus, you'll also have 24-hour access to an Audio Health Library that contains more than 1,500 topics in English and Spanish, as well as current community health concerns and announcements. The health topics include: adult, pediatric, and women's health.

CLINICAL EXPERIENCE

Blue KC 24-hour nurse line nurses have an average of 18 years of clinical experience. They use the latest advancements in technology to assist you in making the right choices involving health issues or concerns. Most importantly, they're available to you 24 hours a day, 7 days a week, 365 days a year.

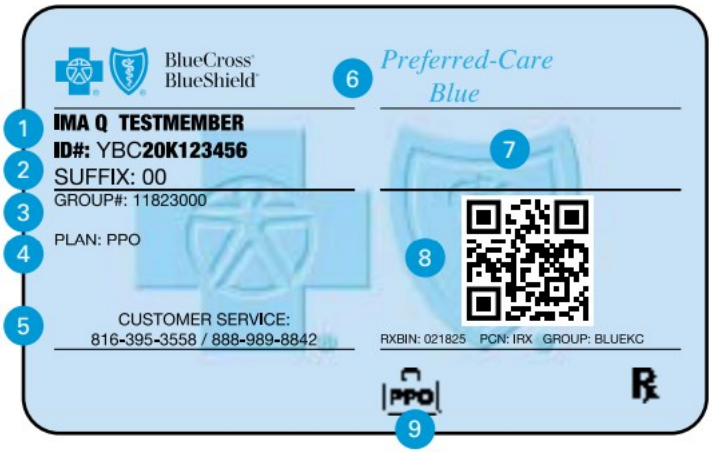
2. BLUE KC NURSE LINE

NURSE LINE

877-852-5422

Call us. You'll be glad you did.

BLUE KC ID CARDS



The Blue Cross and Blue Shield of Kansas City (Blue KC) Card is your key to unlocking all the coverage and benefits your plan has to offer. You can present your card anytime you visit your doctor, receive healthcare services or fill a prescription. It contains everything healthcare professionals need to make sure your care is covered.

FIND A DOCTOR

The Blue KC Provider Finder makes finding an in-network doctor, hospital, or other healthcare provider quick and easy. In addition to viewing basic information, such as medical school attended, residency completed and board of certification status, you can also read patient reviews, rate your doctor and view costs for common procedures.

To view the most accurate information related to your plan, be sure to first log in to www.MyBlueKC.com. By doing so, the results from the Doctor and Hospital Provider Finder will be tailored to your specific Blue KC network.

IDENTIFYING THE INFORMATION ON YOUR MEMBER ID CARD

1. **Member ID Number**—This is the number Blue KC uses to identify you and your policy. Contains a three letter alpha prefix, followed by your ID number. You do not need to include the alpha prefix when providing your member ID number.
2. **Suffix**—This number is unique for each member covered on your policy.
3. **Group Number**—Number Blue KC uses to classify members into groups, usually by your employer.
4. **Plan Type**—This describes what type of insurance plan you have (for example, a PPO plan).
5. **Customer Service Phone Number**—Call this number when you have a question about your Blue KC policy. Blue KC's customer service staff is available Monday through Friday from 8:00am-8:00pm Central Time.
6. **Network Name**—This is the network of hospitals, doctors and other healthcare professionals that accept your Blue KC policy. It's important that you see providers in this network to maximize the benefits of your policy.
7. **In-Network Deductible & Out-of-Pocket—** This space will include your plan's applicable In-Network Deductible and maximum Out-of-Pocket amounts.
8. **QR Code**—Use the camera on your mobile device to scan this code to view your benefit summary.
9. **Suitcase**—Some Blue KC members (excluding HMO plans) have access to the "BlueCard" program, which extends the benefits of your Blue KC plan to all 50 states.

If you ever lose your ID card, you can order a replacement or print a temporary ID card from your member portal at www.MyBlueKC.com.

MINDFUL BY BLUE KC

Introducing Mindful by Blue KC, a new behavioral health initiative dedicated to reducing stigma around behavioral health in our communities while making care accessible and affordable for our members.

Mindful by Blue KC is a commitment to covering the health needs of the whole person. For those we serve, Mindful by Blue KC comes to life as a set of tools and resources to address stress, depression, anxiety, substance use and more. This ensures that our members can access and afford the behavioral healthcare they need.

SERVICES INCLUDE

New! Online Therapy

- Text or scheduled live chat, phone and video therapy, free for up to three sessions, to help with conditions like depression, anxiety and stress (for short-term therapy only and accessible as part of your Well-Being Resources)

New! Online Self-Guided Tools

- Resources to manage stress, improve mood and more

New! Employer Group Workshops

- Educational training sessions for Mental Health First Aid at Work and Building Emotionally Healthy Workplaces

New! Well-Being Resources

- Including up to three visits per issue for help with major life events (divorce, adoption, loss), stress, financial issues, childcare and other everyday challenges

Enhanced! Expedited Access Network

- Team support to find a behavioral health appointment in the earliest window possible for a Blue KC member in crisis

Enhanced! Virtual Care

- With therapists trained and licensed in Virtual Care therapy techniques

Enhanced! Managed Behavioral Health

- Helping members identify in-network providers that best fit their needs by type and specialty

**Blue KC members will pay for services as outlined in their plan benefits. Normal cost-sharing and out-of-pocket maximum limits will apply. The benefits shown above are subject to change.*

3. MINDFUL BY BLUE KC

LEARN MORE

833-302-MIND

www.mindfulbluekc.com

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan.

EMPLOYER CONTRIBUTION

If you enroll in the PCB $5,000 HSA (Base Plan), East Buchanan C-1 School District will contribute $62.50 per month into your HSA Account! ***Please take this into consideration with the annual maximums.***

Contribute up to $3,850 Single, or $7,750 Family

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make extra contributions each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (with a physician's prescription)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Blue KC.
You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from Blue KC that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to www.bluekc.com.

BASIC LIFE/AD&D & DEPENDENT LIFE

BASIC LIFE/AD&D & DEPENDENT LIFE

Employee Basic Life/AD&D

East Buchanan C-1 School District provides $10,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance to all eligible full-time employees.

Coverage terminates upon employee's retirement.

Dependent Life

Spouse: East Buchanan C-1 School District provides $5,000 in Basic Life to eligible spouses.

Spouse coverage terminates at the time the spouse turns 65.

Child(ren): East Buchanan C-1 School District provides $2,500 in Basic Life to eligible child(ren) 6 months and older and $500 to eligible child(ren) 15 days of age up to 6 months of age.

These coverages are offered through USAble Life at no cost to you or your family members.

AGE REDUCTION SCHEDULE

Beginning on the date you reach age 65, your life insurance benefit decreases. Your benefit decreases as follows:

Age Range	Reduces To
65	65%
70	50%

DID YOU KNOW? East Buchanan C-1 School District provides you Basic Life/AD&D AT NO CHARGE.

4. REVIEW YOUR LIFE INSURANCE POLICY

LIFE INSURANCE OFFERS 3 UNIQUE BENEFITS

IT IS PAID DIRECTLY TO YOUR BENEFICIARIES

IT'S NOT SUBJECT TO INCOME TAXES

ITS VALUE IS NOT AFFECTED BY MARKET CONDITIONS

ADDITIONAL MOBILE APPLICATIONS

In addition to your carrier mobile apps, there are several other mobile apps that will help you make this year your best year yet. Here are a few of our favorites:

MyFitnessPal—Allows you to track your fitness activities and food, which gives you a better idea of what you're actually putting into your body.

SleepBot—We all know we could use a little more sleep. This app evaluates your sleep patterns and has a smart alarm, which wakes you up in a light-sleep-stage cycle.

Calm—Meditation helps keep unhealthy stress in check. But if you have no idea what you're doing, this app guides you through meditation of various lengths.

OneRX—Take a picture of your insurance card and this app will give you estimate prescription drug co-pays based on your plan.

C25K—Looking to start running or preparing for a 5k? This app has pre-uploaded training schedules to help get you there.

KingFit—Recently diagnosed with diabetes? Check out this app with loads of educational videos to help you understand how to keep yourself healthy.

Smoke Free—This interactive app allows you to track the number of days you've been smoke free and earn badges for your progress.

Red Cross First Aid—Accidents happen. This app provides simple step-by-step instructions to help guide you through everyday first aid scenarios.

GoodRX—Compare prescription drug prices and find coupons at more than 60,000 US pharmacies. Save up to 80% instantly!

Mint—Financial concerns are the number one reason for stress. Help manage that stress by streamlining your finances and budgets using this app.

CareZone—This app lets you curate a list of medications, dosages and schedules to make sure your managing your care. And you can share with your family or doctor directly from the app.

GLOSSARY OF TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from East Buchanan C-1 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 East Buchanan C-1 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. East Buchanan C-1 School District has determined that the prescription drug coverage offered by the Blue KC health 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 East Buchanan C-1 School District coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the East Buchanan C-1 School District medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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

You should also know that if you drop or lose your current coverage with East Buchanan C-1 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 East Buchanan C-1 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 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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: April 25, 2023
Name of Entity/Sender: East Buchanan C-1 School District
Contact--Position/Office: Beth Carr | carr@ebs.k12.mo.us | 816-424-6466
Address: 100 Smith St Gower, MO 64454
Phone Number: 816-424-6466

This notice is a summary. For a full description of all of East Buchanan C-1 School District's Benefit plans, please refer to the Summary Plan Descriptions, located at: Human Resources.

IMPORTANT NOTICES

MEDICAID CHIP NOTICE

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 July 31, 2022. Contact your State for more information on eligibility—

ALABAMA—Medicaid	CALIFORNIA—Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**Health Insurance Premium Payment (HIPP) Program Website:** http://dhcs.ca.gov/hipp **Phone:** 916-445-8322 **Fax:** 916-440-5676 **Email:** hipp@dhcs.ca.gov
ALASKA—Medicaid	**COLORADO—Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/Pages/default.aspx	**Health First Colorado Website:** https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943 / State Relay 711 **CHP+:** https://www.colorado.gov/pacific/hcpf/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991 / State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program **HIBI Customer Service:** 1-855-692-6442
ARKANSAS—Medicaid	**FLORIDA—Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268

IMPORTANT NOTICES

GEORGIA—Medicaid	MASSACHUSETTS —Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 678-564-1162, Press 1 **GA CHIPRA Website:** https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra **Phone:** 678-564-1162, Press 2	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840 **TTY:** 617-886-8102
INDIANA—Medicaid	**MINNESOTA—Medicaid**
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:** https://www.in.gov/medicaid/ **Phone:** 1-800-457-4584	**Website:** https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp **Phone:** 1-800-657-3739
IOWA—Medicaid and CHIP (Hawki)	**MISSOURI—Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** http://dhs.iowa.gov/Hawki **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **HIPP Phone:** 1-888-346-9562	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
KANSAS—Medicaid	**MONTANA—Medicaid**
Website: https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084 **Email:** HHSHIPPProgram@mt.gov
KENTUCKY—Medicaid	**NEBRASKA—Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx **Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP Website:** https://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178
LOUISIANA—Medicaid	**NEVADA—Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid Hotline) or 1-855-618-5488 (LaHIPP)	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900

IMPORTANT NOTICES

MAINE—Medicaid	NEW HAMPSHIRE—Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 1-800-442-6003 **TTY:** Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 800-977-6740 **TTY:** Maine relay 711	**Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Phone:** 603-271-5218 **Toll Free Number for the HIPP Program:** 1-800-852-3345, ext. 5218
NEW JERSEY—Medicaid and CHIP	**SOUTH DAKOTA—Medicaid**
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	**Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
NEW YORK—Medicaid	**TEXAS—Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831	**Website:** http://gethipptexas.com/ **Phone:** 1-800-440-0493
NORTH CAROLINA—Medicaid	**UTAH—Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100	**Medicaid Website:** https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
NORTH DAKOTA—Medicaid	**VERMONT—Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** 1-844-854-4825	**Website:** http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427
OKLAHOMA—Medicaid and CHIP	**VIRGINIA—Medicaid and CHIP**
Website: http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**Website:** https://www.coverva.org/en/famis-select & https://www.coverva.org/en/hipp **Medicaid Phone:** 1-800-432-5924 **CHIP Phone:** 1-800-432-5924
OREGON—Medicaid	**WASHINGTON—Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx & http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075	**Website:** https://www.hca.wa.gov/ **Phone:** 1-800-562-3022
PENNSYLVANIA—Medicaid	**WEST VIRGINIA—Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx **Phone:** 1-800-692-7462	**Website:** https://dhhr.wv.gov/bms/ & http://mywvhipp.com/ **Medicaid Phone:** 304-558-1700 **CHIP Toll-Free Phone:** 1-855-MyWVHIPP (1-855-699- 8447)

IMPORTANT NOTICES

RHODE ISLAND—Medicaid and CHIP	WISCONSIN—Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002
SOUTH CAROLINA—Medicaid	**WYOMING—Medicaid**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone:** 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, 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 and 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

East Buchanan C-1 School District has amended the Medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

IMPORTANT NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please contact Beth Carr at 816-424-6466.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- are past, or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service;

then an employer may not deny you:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor: 1-866-487-2365

U.S. Department of Justice | Office of Special Counsel

Employer Support of the Guard and Reserve: 1-800-336-4590

Publication Date—April 2017

INITIAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following

qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 East Buchanan C-1 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. 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- 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).

For all 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:** Beth Carr.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage—

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage—

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions -

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes -

To protect your family's rights, let the Plan Administrator know about 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 -

Beth Carr

carr@ebs.k12.mo.us

816-424-6466

This notice is intended as a brief outline; please see HR for more information.

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. 1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact East Buchanan C-1 School District's HR department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

IMPORTANT NOTICES

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: East Buchanan C-1 School District	**Employer Identification Number (EIN):** 43-0893695
Employer Address: 100 Smith St Gower, MO 64454	**Employer Phone Number:** 816-424-6466
Who can we contact about employee health coverage at this job? Beth Carr	**Phone Number:** 816-424-6466 **Email Address:** carr@ebs.k12.mo.us

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  ☑ Full time employees, working a minimum of 30 hours per week on a regular basis. Employees will be effective the first of the month, following date of hire.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: an employee's legal spouse, an employee's disabled child (as defined by the Plan), and an employee's natural child, adopted child, or stepchild who has not reached age 26.

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.healthcare.gov to find out if you can get a tax credit to lower your monthly premiums.

EAST BUCHANAN C-1 SCHOOL DISTRICT

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.