

USD # 500



ENROLLMENT TOOLKIT

FOR BENEFITS EFFECTIVE JULY 1, 2012 THROUGH DECEMBER 31, 2012

WELCOME

Welcome to the **Spring 2012 USD # 500 Benefits Program**. This enrollment guide outlines your benefit program and what options are available to you. It is important that you review this information and understand how to use the various programs to maximize your benefits package. The programs outlined in this booklet give you a tremendous opportunity to protect you and your family.

From medical benefits to voluntary benefits offering financial protection, it's all included in a comprehensive package from USD #500 designed to take care of you now and in the future.

NOTE

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, insurance contracts, and Board Policy and not by this booklet. If there is any discrepancy between the descriptions of the Plans as described in this booklet and the official Plan documents and Board Policy, the language of the Plan documents shall govern.

To obtain a copy of the official Plan documents, simply log on to the Employee Service Center website at www.cbizesc.com/kckps, select the plan you wish to obtain a document for and select "Summary Plan Description." You can then either view the appropriate Plan document or print a copy for your records. You may also contact the individual carrier to request a copy be sent to you.

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ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE?

All certified and full-time classified employees working 30 hours or more per week are considered eligible to participate. Please discuss with Human Resources your employment status to determine eligibility and your benefit effective date.

Dependents of eligible employees may also be eligible for coverage under many of these benefit plans. Eligible dependents include:

- Your spouse;
- Unmarried children through the end of the calendar year (December 31) in which they turn 26;
- Unmarried dependent children over age 26 who are incapable of supporting themselves because of mental or physical handicaps (upon approval).

OPEN ENROLLMENT

Each year during Open Enrollment, you have the opportunity to re-evaluate your benefit needs and adjust your coverage for the upcoming plan year. Even if you are not making any changes, you must re-enroll. If you fail to enroll by the May 25, 2012 deadline, your benefits will be waived effective July 1, 2012. Remember, once you make selections, you may not change your benefits until the next open enrollment period unless there is a qualifying status change. All changes made during Spring Open Enrollment are effective July 1, 2012.



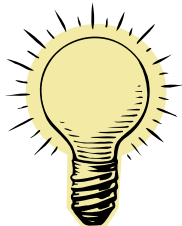
Due to upcoming changes in the U.S.D #500 benefits plan year, please be advised that all benefits selected during spring open enrollment will be valid for six months (*July 1, 2012 – December 31, 2012*). An additional open enrollment will be provided to all employees in Fall 2012; that will change the benefits effective date to January 1, 2013. For questions regarding this transition, please contact the Benefits Office.

Active Employees

All enrollment and mid-year qualifying status changes are done through the internet. To enroll or make changes, simply access the Employee Service Center at www.cbizesc.com/kckps.

Retiree & COBRA Participants

You will receive a paper enrollment form in the mail that you will need to complete and send back by the deadline listed on the form.



IMPORTANT:

It is very important that you complete your enrollment by the deadline listed on your enrollment worksheet. If you do not complete your enrollment by the deadline, you will have no coverage for the plan year.

New Hires

To enroll, simply access the Employee Service Center at www.cbizesc.com/kckps. If you don't enroll in your benefits within 31 days of first becoming eligible, you must wait until the next Open Enrollment period. It is your responsibility to enroll during your 31-day eligibility period.

QUALIFYING STATUS CHANGES

If you experience a qualifying status change during the plan year, you may make changes to some benefits within 31 days of the event. The changes you request must be consistent with the status change event.

Qualifying Status Changes Include:

- Marriage
- Birth or adoption of your child
- Death of your spouse or child
- Divorce, legal separation or annulment
- Change in your child's dependent status
(age requirement, obtaining other coverage, marriage)
- Change in your or your spouse's employment status
(part-time to full-time, commence new job or gain coverage availability)



- You must notify the Employee Service Center at www.cbizesc.com/kckps within 31 days of a qualifying status change to adjust benefits. If the Employee Service Center is not notified within this time frame, you must wait until the next Open Enrollment period to adjust your benefits.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll in USD #500's plan; you must request enrollment within 60 days. Additionally, 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 USD #500's plan; you must request enrollment within 60 days.

▮ MEDICAL BENEFITS ▮

BLUE CROSS BLUE SHIELD OF KANSAS CITY

When it comes to benefits, we recognize that one size doesn't fit all. We understand that people are different with different lifestyles and needs. Situations change. That's why the USD #500 plan offers you four levels of coverage insured through Blue Cross Blue Shield of Kansas City (Blue KC). You have your choice of three PPO plans and one HMO plan. The difference in each plan is the out-of-pocket cost to you and the premium you pay. On each plan, you have the option to choose between four levels of coverage: Employee Only, Employee & Spouse, Employee & Child (ren), or Employee & Family.

WEIGH YOUR OPTIONS

When choosing a health benefits plan, the most important question is: Will it provide the right amount of coverage for you and your family? After deciding how much coverage you need, consider the costs – and when you pay them.



There are two ways you contribute to the cost of a health plan:

1. **Up-front costs.** This is the part of the health insurance premium you pay. If you're an employee, up-front costs are deducted from your paycheck. If you're retired or on a non-employee plan like COBRA, you write a check or bank draft for the premium. Either way, you pay premium costs regularly, like any bill, no matter how often – or how seldom – you need health care.
2. **Pay-as-you-go costs.** These are the out-of-pocket dollars you pay when you see a doctor, go to a hospital or outpatient clinic, or have a prescription filled. Pay-as-you-go costs include copayments, deductibles, and coinsurance.

If you need medical care often, you might want to pay more up-front and less as-you-go costs. Budgeting is easier because your premium costs are always the same, and you won't have huge expenses for any major, unexpected medical treatment.

If you see a doctor or need prescriptions only two or three times a year, it might make more sense to pay less up-front and more as-you-go. This way, you can save the premiums and avoid paying for more coverage than you might use.



BLUE KC CHOICES

Making the right choices and becoming more knowledgeable about your plan options helps you be a better health care consumer. The plan you choose should simply be the one you're most comfortable with – a plan that fits your health needs, budget, and personal preferences. No matter which plan you enroll in, you'll have the assurance of some financial protection against any major, unexpected medical expenses that are covered by your plan.

Your choices include all of the plans briefly described below. For more details, refer to the plan descriptions on the following pages.

- **HMO.** With an HMO (Health Maintenance Organization), there's no deductible. Your share of the costs includes copayments for many services. You choose a primary care physician (PCP) who will provide most of your care and recommend specialists as needed. To visit a specialist who participates in the Blue Care Network, simply select the specialist and make an appointment. No referral is required. An HMO generally does not cover any services from non-participating providers, except for emergencies.
 - The HMO plan utilizes the **Blue Care Network**.

- **PPO.** A PPO (Preferred Provider Organization) allows you to see participating and non-participating providers.
 - The PPO plans utilize the **Preferred Care Blue Network**.
 - **First Dollar Coverage.** Two of the PPO plans offered through BCBS offer first dollar coverage. For each covered person, one plan pays up to the first \$500 of eligible expenses for covered services from participating providers, and the other plan pays up to the first \$250 of eligible expenses. The calendar year benefit does not apply to copayments, office visits, prescription drugs, or any services from non-participating providers. Once the plan has paid the First Dollar Amount, you pay all other expenses until you reach your deductible. The plan offers a good option if you rarely visit the doctor or take prescription medications and it includes a safety net to cover a catastrophic health event, such as serious illness or injury.



To obtain a list of providers participating in either network, visit www.bluekc.com. Select the blue box on the top right hand side of the page "Find Blue KC Doctors, Hospitals, & Pharmacies." When selecting your insurance plan, choose Blue Care Network for the HMO plans and Preferred Care Blue Network for the PPO plans. Providers are subject to change at anytime.



VALUE BASED PRESCRIPTION DRUG PROGRAM

Blue Cross and Blue Shield of Kansas City (Blue KC) now offers a unique program for members with Diabetes & Coronary Artery Disease. When you seek appropriate treatment, this incentive based program helps reduce financial barriers by combining education and support as well as waived or reduced co pays for selected medications or supplies. For more information regarding this program, contact Blue KC Customer Service by calling the number on your member ID card.

MAIL ORDER PRESCRIPTION DRUGS

If you are taking prescription medications on a regular, on-going basis, you can save money by ordering them through the Express Scripts Home Delivery program.



Home Delivery offers the following benefits:

- Prescriptions are delivered directly to your home – with free standard shipping.
- You get up to a 3-month supply of your medications for two co pays.
- You can speak with a pharmacist anytime, day or night.
- Once you begin using Home Delivery, you can order refills by phone or online.

YOUR MEDICAL PLANS IN ACTION

Let's take a look at three very different situations and compare the medical plan options side-by-side – based on our assumptions about the health care the member will need during the year. For all three examples, all care will be provided within the appropriate Blue KC network, any prescription drugs are not included, and each employee participated in the Fit500 screening & completed the online HRA. Consider your own personal situation in a similar manner to help you make informed decisions and choose the most affordable medical plan that best meets your healthcare needs. Remember, these are just illustrations and are not intended to fit every situation.



Karen leads a very active lifestyle. She usually goes to her Primary Care Physician (PCP) once a year for her routine physical and recommended screenings. In January, her PCP recommended that she have some moles removed from her back. She had an outpatient service at her PCP's office in February. Following is an estimate of Karen's out-of-pocket costs:

KAREN

	\$2,500 PPO	\$1,000 PPO	PPO \$500	HMO 1
PCP Office Visit	\$50	\$50	\$50	\$50
Karen's Copayment*	\$0	\$0	\$0	\$0
<i>*Routine preventive care is covered at 100% with no co pay</i>				
BCBS Paid	\$50	\$50	\$50	\$50
Outpatient Surgery Cost	\$400	\$400	\$400	\$400
Karen's Copayment	\$0	\$0	\$0	\$300
Benefit Allowance (paid by BCBS)	\$250	\$400	N/A	N/A
Karen's Deductible	\$150	\$0	\$400	\$0
Karen's Coinsurance	\$0	\$0	\$0	\$0
BCBS Coinsurance	\$0	\$0	\$0	\$100
Total BCBS Paid	\$300	\$450	\$50	\$150
Summary of Karen's Costs				
Medical Expenses	\$150	\$0	\$400	\$300
Total Annual Premium	\$0	\$ 573.36	\$ 1,776.96	\$1798.08
Karen's Total Annual Cost	\$150.00	\$ 573.36	\$2,176.96	\$2,098.08



BRENDA

Brenda considers herself to be a relatively healthy individual. This year she got a very bad cold that was diagnosed as pneumonia. She saw her Primary Care Physician (PCP) two times while ill and had blood tests and a chest x-ray upon diagnosis and then additional blood tests and a chest x-ray once she was feeling better. Following is an estimate of Brenda's out of pocket costs:

	\$2,500 PPO	\$1,000 PPO	PPO \$500	HMO 1
PCP Office Visits (2)	\$300	\$300	\$300	\$300
Brenda's Copayments	\$50	\$ 50	\$50	\$ 50
BCBS Paid	\$250	\$250	\$250	\$250
Lab & X-ray (2)	\$700	\$700	\$700	\$700
Benefit Allowance (paid by BCBS)	\$250	\$500	N/A	N/A
Brenda's Deductible	\$450	\$200	\$500	\$0
Brenda's Coinsurance	\$0	\$0	\$20	\$0
BCBS Coinsurance	\$0	\$0	\$180	\$700
Total BCBS Paid	\$500	\$ 750	\$430	\$950
Summary of Brenda's Costs				
Medical Expenses	\$500	\$ 250	\$570	\$50
Total Annual Premium	\$0	\$ 573.36	\$ 1,776.96	\$1,798.08
Brenda's Total Annual Cost	\$500.00	\$823.36	\$2,346.96	\$1,848.08



ROBERT

Robert experienced some stomach pain this year and went to see his Primary Care Physician (PCP). Upon examination, his PCP admitted him to the hospital due to appendicitis. Robert's condition required surgery and additional services from a physician and anesthesiologist. He was in the hospital for two days. Following is an example of Robert's out-of-pocket costs:

	\$2,500 PPO	\$1,000 PPO	PPO \$500	HMO 1
PCP Office Visit	\$150	\$150	\$150	\$150
Robert's Copayments	\$25	\$25	\$25	\$ 25
BCBS Paid	\$125	\$125	\$125	\$125
Hospital Care	\$7,000	\$7,000	\$7,000	\$7,000
Inpatient Physician Services	\$3,500	\$3,500	\$3,500	\$3,500
Anesthesiology	\$1,500	\$1,500	\$1,500	\$1,500
Robert's Copayments	\$600	\$400	\$400	\$600
Benefit Allowance (paid by BCBS)	\$250	\$500	N/A	N/A
Robert's Deductible	\$2,500	\$1,000	\$500	\$0
Robert's Coinsurance	\$0	\$0	\$0	\$0
BCBS Coinsurance	\$8,900	\$10,600	\$11,100	\$11,400
Total BCBS Paid	\$9,025	\$10,725	\$11,225	\$11,525
Summary of Robert's Costs				
Medical Expenses	\$3,125	\$1,425	\$925	\$625
Total Annual Premium	\$0	\$573.36	\$1,776.96	\$1798.08
Robert's Total Annual Cost	\$3,125.00	\$1,998.36	\$2,701.96	\$2423.08

Blue Cross Blue Shield of Kansas City Plan Designs
Effective July 1, 2012

	BCBSKC \$2,500 PPO with First Dollar Coverage	
	Participating Providers	Non-Participating Providers
Benefit Allowance¹		
Per Member	\$250 per calendar year	N/A
Annual Deductibles (calendar year)		
Single	\$2,500	\$5,000
Family	\$7,500	\$10,000
Out-of-Pocket Amounts (calendar year)²		
Single	\$2,500	\$7,500
Family	\$7,500	\$22,500
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
Adult & Child Routine Physicals	100% after \$0 co pay	70% after deductible
Routine Lab ³	100%	70% after deductible
Routine Mammogram ³	100%	70% after deductible
Vision Exam	100% after \$25 co pay	70% after deductible
Physician Services		
Primary Care Physician Office Visit	100% after \$25 co pay ⁴	70% after deductible
Specialist Office Visit	100% after \$50 co pay ⁴	70% after deductible
Non-routine diagnostic tests and labs	100% after deductible	70% after deductible
Hospital Services		
Inpatient Care	100% after \$600 co pay & deductible Copoly is charged once per admission	70% after deductible ⁵
Outpatient Surgery	100% after deductible	70% after deductible ⁵
Outpatient nonsurgical care (i.e. MRI)	100% after deductible	70% after deductible ⁵
Urgent Care	100% after \$50 co pay ⁶	70% after deductible
Emergency Room	100% after \$200 co pay & deductible	100% after \$200 co pay & in-network deductible
Prescription Drugs		
Calendar Year Deductible	Participating Pharmacy \$300 Individual/ \$900 Family (waived upon completion of HRA & Health Screening)	
Level 1	\$15 co pay (\$0 Copay for Value Based)	
Level 2	\$30 co pay (\$0 Copay for Value Based)	
Level 3	\$50 co pay (\$25 Copay for Value Based)	
Mail Order (102 day supply)	2 times retail co pay	

	BCBSKC \$1,000 PPO with First Dollar Coverage	
	Participating Providers	Non-Participating Providers
Benefit Allowance¹		
Per Member	\$500 per calendar year	N/A
Annual Deductibles (calendar year)		
Single	\$1,000	\$3,000
Family	\$3,000	\$9,000
Out-of-Pocket Amounts (calendar year)²		
Single	\$3,000	\$9,000
Family	\$9,000	\$27,000
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
Adult & Child Routine Physicals	100% after \$0 co pay	70% after deductible
Routine Lab ³	100%	70% after deductible
Routine Mammogram ³	100%	70% after deductible
Vision Exam	100% after \$25 co pay	70% after deductible
Physician Services		
Primary Care Physician Office Visit	100% after \$25 co pay ⁴	70% after deductible
Specialist Office Visit	100% after \$50 co pay ⁴	70% after deductible
Non-routine diagnostic tests and labs	80% after deductible	70% after deductible
Hospital Services		
Inpatient Care	100% after \$400 co pay & deductible Copoly is charged once per admission	70% after deductible ⁵
Outpatient Surgery	80% after deductible	70% after deductible ⁵
Outpatient nonsurgical care (i.e. MRI)	80% after deductible	70% after deductible ⁵
Urgent Care	100% after \$50 co pay ⁶	70% after deductible
Emergency Room	80% after \$200 co pay & deductible	80% after \$200 co pay & in-network deductible
Prescription Drugs		
Calendar Year Deductible	Participating Pharmacy \$300 Individual/ \$900 Family (waived upon completion of HRA & Health Screening)	
Level 1	\$15 co pay (\$0 Copay for Value Based)	
Level 2	\$30 co pay (\$0 Copay for Value Based)	
Level 3	\$50 co pay (\$25 Copay for Value Based)	
Mail Order (102 day supply)	2 times retail co pay	

¹ Benefit Allowance does not apply to office visits (regardless if routine or diagnostic) or prescription drugs.

² PPO out-of-pocket amount includes coinsurance and deductible but excludes co pays. HMO out-of-pocket amount includes co pays unless otherwise noted.

³ Office visit co pay will apply if service is performed in conjunction with an office visit.

⁴ Office visit co pay applies to specified services; any non-specified services will be subject to deductible and coinsurance.

⁵ Diagnostic services performed at a non-par imaging center within the service area are limited to \$200 CY Max. Inpatient services in a non-par hospital within the service area are limited to \$200 max per day and are limited to 30 days per CY. Outpatient services at a non-par facility (including ambulatory surgical center) are limited to \$200 CY Max.

⁶ Urgent care co pay applies to office visit and lab only. Other services performed by Urgent Care provider are subject to deductible and coinsurance.

⁷ Copay applies only to MRI, MRA, CT and PET scans performed in physician's office, imaging center or other outpatient setting (including hospital). Only one co pay will apply for each provider on a specified date of service even if multiple scans are performed.

Blue Cross Blue Shield of Kansas City Plan Designs
Effective July 1, 2012

	BCBSKC PPO\$500	
	Participating Providers	Non-Participating Providers
Benefit Allowance¹		
Per Member	N/A	N/A
Annual Deductibles (calendar year)		
Single	\$500	\$1,000
Family	\$1,500	\$3,000
Out-of-Pocket Amounts (calendar year)²		
Single	\$2,500	\$5,000
Family	\$7,500	\$15,000
Lifetime Maximum Benefit	Unlimited	
Preventive Care		
Adult & Child Routine Physicals	100% after \$0 co pay	70% after deductible
Routine Lab ³	100%	70% after deductible
Routine Mammogram ³	100%	70% after deductible
Vision Exam	100% after \$25 co pay	70% after deductible
Physician Services		
Primary Care Physician Office Visit	100% after \$25 co pay ⁴	70% after deductible
Specialist Office Visit	100% after \$50 co pay ⁴	70% after deductible
Non-routine diagnostic tests and labs	90% after deductible	70% after deductible
Hospital Services		
Inpatient Care	100% after \$400 co pay & deductible Copoly is charged once per admission	70% after deductible ⁵
Outpatient Surgery	80% after deductible	70% after deductible ⁵
Outpatient nonsurgical care (i.e. MRI)	90% after deductible	70% after deductible ⁵
Urgent Care	100% after \$50 co pay ⁶	70% after deductible
Emergency Room	90% after \$200 co pay & deductible	90% after \$200 co pay & in-network deductible
Prescription Drugs		
Calendar Year Deductible	Participating Pharmacy \$300 Individual/ \$900 Family (waived upon completion of HRA & Health Screening)	
Level 1	\$15 co pay (\$0 Copay for Value Based)	
Level 2	\$30 co pay (\$0 Copay for Value Based)	
Level 3	\$50 co pay (\$25 Copay for Value Based)	
Mail Order (102 day supply)	2 times retail co pay	

BCBSKC HMO 1	
Participating Providers	
Benefit Allowance ¹	
N/A	
Annual Deductibles (calendar year)	
N/A	
Out-of-Pocket Amounts (calendar year) ²	
\$1,500 per member (hospital co pays only)	
\$1,500 per member (hospital co pays only)	
Unlimited	
Preventive Care	
100% after \$0 co pay	
100%	
100%	
100% after \$10 co pay	
Physician Services	
100% \$25 co pay	
100% after \$50 co pay	
100%	
Hospital Services	
\$300 co pay per day Copoly is charged per day for the first 5 days per calendar year (IP & OP combined)	
\$300 co pay/Occurrence	
100% after \$200 co pay	
100% after \$50 co pay	
100% after \$200 co pay	
Prescription Drugs	
Participating Pharmacy \$300 Individual/ \$900 Family (waived upon completion of HRA & Health Screening)	
\$15 co pay (\$0 Copay for Value Based)	
\$30 co pay (\$0 Copay for Value Based)	
\$50 co pay (\$25 Copay for Value Based)	
2 times retail co pay	

¹ Benefit Allowance does not apply to office visits (regardless if routine or diagnostic) or prescription drugs.

² PPO out-of-pocket amount includes coinsurance and deductible but excludes co pays. HMO out-of-pocket amount includes co pays unless otherwise noted.

³ Office visit co pay will apply if service is performed in conjunction with an office visit.

⁴ Office visit co pay applies to specified services; any non-specified services will be subject to deductible and coinsurance.

⁵ Diagnostic services performed at a non-par imaging center within the service area are limited to \$200 CY Max. Inpatient services in a non-par hospital within the service area are limited to \$200 max per day and are limited to 30 days per CY. Outpatient services at a non-par facility (including ambulatory surgical center) are limited to \$200 CY Max.

⁶ Urgent care co pay applies to office visit and lab only. Other services performed by Urgent Care provider are subject to deductible and coinsurance.

⁷ Copay applies only to MRI, MRA, CT and PET scans performed in physician's office, imaging center or other outpatient setting (including hospital). Only one co pay will apply for each provider on a specified date of service even if multiple scans are performed.

Note: This is only a summary. Please refer to the booklet/certificate for specific details. If a conflict arises, the booklet/certificate will govern in all cases.

Note: This is not an offer of insurance coverage. Information on final rates, coverage's, and limitations must come from the Insurance Company.



Employee Wellness Program

The vision of the Fit500 employee wellness program is to empower USD 500 employees to take responsibility for their own health and healthcare decisions. By doing so, we will foster more productive employees, healthier families and well-being of our community.

The Fit500 wellness program is a voluntary and confidential program to assist you in managing your health. USD 500 believes a healthy, vibrant workforce is a key component to our success and growth. The Fit500 wellness program offers a variety of opportunities for you to improve and maintain your health.

To assist in providing the necessary tools and wellness resources to you, the District has partnered with BCBSKC & CBIZ to provide employees with wellness services.



Details about incentive programs, screenings, and wellness activities are posted in the employee SIP as well as on the District website - <http://www.kckps.org/wellness/>

For more information contact: Fit500 Wellness Coordinator at 913.279.2030

As part of the District's initiative to focus on employee wellness, both on-site screenings and the opportunity to complete a Health Risk Appraisal are offered annually to all employees at no charge. On-site health screenings include Height, Weight, BMI, Cholesterol, HDL, Glucose, and a confidential review with a nurse about your results.

Important to Know:

- All health screening and Health Risk Appraisal results are kept completely **confidential**. We will never see your individual results.
- Employees who were covered under the District's health insurance plan between July 1, 2011 and February 1, 2012 are required to complete the both health screening and the online Health Risk Appraisal by the previously communicated deadline of April 20, 2012 in order to qualify for the \$300 prescription drug deductible waiver, effective July 1, 2012.
- Failure to meet this requirement will result in a \$300 prescription drug deductible (\$900 family) effective July 1, 2012.
- New employees hired after February 1, 2012 will have the above wellness program requirements waived and will automatically receive the prescription drug deductible waiver for the benefit year effective July 1, 2012. You will be required to complete the requirements in subsequent years.
- At this time, if you are a retiree or COBRA participant, you are not required to complete the wellness program requirements and you will automatically have the prescription drug deductible waived.

IMPORTANT: The Health Risk Appraisal & Health Screening will be used for health management purposes only. Your information is not used to deny coverage nor is it used to impose pre-existing condition limitations. Completion of these requirements is voluntary, but if not completed you will have a \$300 Prescription Drug Deductible (\$900 family).

Feel Better. Look Better. Live Better.

Blue Cross Blue Shield of Kansas City is committed to helping you improve your total health and well-being. That is why they have developed **A Healthier You**, to give you the resources and tools you need to get and stay healthier.

A Healthier You is a comprehensive portfolio of tools and services that Blue Cross Blue Shield of Kansas City members can access both at work and at home. The goal of the program is to help members establish and maintain a healthy lifestyle. Blue Cross Blue Shield of Kansas City provides this program because investing in your health pays big dividends in lower healthcare costs and higher job satisfaction.

A Healthier You is all about making it easy for you to set a course for better health and stay the course until you are feeling better, looking better and living better every day.



┌ DENTAL BENEFITS ┐

GUARDIAN

Maintaining good oral health is very important to the overall well-being of employees and their families. That is why USD #500 offers you the choice between two dental plans that are flexible enough to respond to a variety of dental care needs. Whether you need a check-up, a filling, or major dental work, the Guardian plans cover you.

YOUR CHOICES

The Guardian plans allow you to receive services from any dentist. But, for maximum cost savings, you should choose a dentist who participates in the Guardian DentalGuard Preferred PPO network. Participating DentalGuard Preferred dentists cannot bill you for any charges that are in excess of Guardian's reasonable & customary amount, and they have discounted the fees that they do charge. Participating dentists will also file your claims directly with Guardian, so you won't have to file any paperwork.

You do have the option of going outside the DentalGuard Preferred network for services. Should you choose to do so, you may have a reduced benefit. In addition, a non-participating dentist can bill you the excess over Guardian's reasonable and customary amount. You may also have to pay the cost for the total services up front and then submit a claim to Guardian directly.



To obtain a list of dentists participating in the network, visit www.guardianlife.com. Select "Provider Online Search" in the gray box on the right hand side of the page. Then select "Find a Dentist." When selecting your insurance plan choose "PPO" and when selecting your network, choose "DentalGuard Preferred."



Predetermination

A predetermination of benefits is simply a notification to you and your dentist as to whether the procedures recommended are within the services covered by the Guardian contract. By obtaining a predetermination from Guardian prior to receiving dental services, you have the security of knowing in advance the percentage Guardian will pay, how much you will be responsible for out of pocket and whether the services recommended by your dentist fall within the benefit maximums and procedure limitations.

Guardian suggests having a predetermination for all services that exceed \$300. You or your dental provider can submit the predetermination by sending Guardian an itemized bill or a completed claim form with the following information:

- Patient name
- Member name or Group Number
- ID #
- Procedure codes
- Teeth #
- Fee
- DDS name and address

The predetermination can be submitted directly to the Guardian Dental Claims Department at:

Email: cru@glic.com

Fax: (509) 465-3404

Once the services are completed, your dentist can fill in the dates of service, sign the predetermination and submit it to Guardian for processing.

MAXIMUM ROLLOVER

Guardian will roll over a portion of each member's unused annual maximum into your Maximum Rollover Account (MRA). The MRA can be used in future years if a member reaches the plan's annual maximum.

To qualify, you must submit a claim and not exceed the paid claims threshold during the benefit year. You and each of your dependents maintain separate MRAs based on your own claim activity. Each member's MRA may not exceed the MRA limit.



Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Maximum Rollover Amount	MRA Limit
\$1,000	\$500	\$250	\$350	\$1,000

**If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits (\$2,000 PPO/\$1,000 non-PPO), the non-PPO maximum determines the Maximum Rollover plan.*

Low Plan – DentalGuard Preferred Network

Dental Plan Features	In-Network	Out-of-Network (Based on In-Network Established Fee Schedule)
Preventive Services (not subject to the deductible) <ul style="list-style-type: none"> • Oral Examination – every six months • Teeth Cleaning – every six months • X-Rays – four bitewings every twelve months • Periodontal Maintenance Procedure – every six months • Emergency Palliative Treatment • Fluoride Treatments – every six months (to age 19) • Space Maintainers for Children (under age 14) • Topical Sealants for un-restored molar teeth – one treatment for children under age 14 in a three year period 	100%	100%
Basic Services <ul style="list-style-type: none"> • Fillings – amalgam & anterior composites • X-Rays – full mouth series every five years • Periodontal Services (other than Periodontal Maintenance Procedure) • Endodontic Services/Root Canal Therapy • Diagnostic Consultation – one per year • Crowns – stainless steel • General Anesthesia – surgical procedures only • Injectable Antibiotics – for treatment of a dental condition only • Laboratory Test • Repairs of dentures, bridgework, crowns, etc. 	80%	80%
Major Services <ul style="list-style-type: none"> • Oral Surgery • Crowns – resin, metal • Bridges Installation – fixed and removable • Dentures – full and partial • Inlays, Onlays, Posts • TMJ – annual limit of \$200 	40%	40%
Orthodontic Services (not subject to the deductible) <ul style="list-style-type: none"> • Children under age 19 • Not subject to Maximum Rollover 	40%	40%
Lifetime Orthodontic Maximum (per child)	\$1,000	\$1,000
Calendar Year Deductible (per person, maximum 3 per family)	\$50	\$50
Calendar Year Annual Maximum (per person)	\$1,000	\$1,000

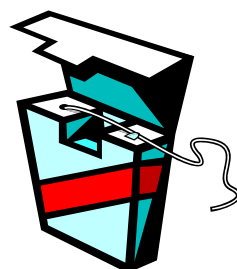
In-network and out-of-network benefits receive the same coinsurance percentages, but all benefits are paid based on the contracted fee schedule. When seeking in-network care, you receive regular contracted savings and no balance billing. If choosing out-of-network care, charges will be paid for only up to the maximum feel level established with Guardian's contracted network dentists; any amount that is charged over the fee schedule is the responsibility of the patient.

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.

High Plan – DentalGuard Preferred Network

Dental Plan Features	In-Network	Out-of-Network
Preventive Services (not subject to the deductible) <ul style="list-style-type: none"> • Oral Examination – every six months • Teeth Cleaning – every six months • X-Rays – four bitewings every twelve months; • Periodontal Maintenance Procedure – every six months • Emergency Palliative Treatment • Fluoride Treatments – every six months (to age 19) • Space Maintainers for Children (under age 14) • Topical Sealants for un-restored molar teeth – one treatment for children under age 15 in a three year period 	100%	90%
Basic Services <ul style="list-style-type: none"> • Fillings – amalgam & anterior and posterior composites • X-Rays – full mouth series every five years • Periodontal Services (other than Periodontal Maintenance Procedure) • Endodontic Services/Root Canal Therapy • Diagnostic Consultation – one per year • Crowns – stainless steel • General Anesthesia – surgical procedures only • Injectable Antibiotics – for treatment of a dental condition only • Laboratory Test • Repairs of dentures, bridgework, crowns, etc. 	80%	60%
Major Services <ul style="list-style-type: none"> • Oral Surgery • Crowns – resin, metal • Bridges Installation – fixed and removable • Dentures – full and partial • Inlays, Onlays, Posts • TMJ – annual limit of \$200 	60%	40%
Orthodontic Services (not subject to the deductible) <ul style="list-style-type: none"> • Children under age 19 • Not subject to Maximum Rollover 	50%	40%
Lifetime Orthodontic Maximum (per child)	\$1,000	\$1,000
Calendar Year Deductible (per person, maximum 3 per family)	\$0	\$25
Calendar Year Annual Maximum (per person)	\$2,000	\$1,000

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.



VISION BENEFITS

SUPERIOR VISION



USD #500 offers you an affordable, simple-to-use plan to keep your eyes healthy. By enrolling in this plan, you will have coverage for annual routine eye exams, materials and contact lenses. You can use any provider; however, you will receive a higher level of benefits should you receive your care from a participating Superior Vision provider. To locate a provider participating in the Superior Vision network, simply visit www.superiorvision.com and select "Locate a Provider."

Vision Highlights	
In-Network Benefits	
Benefit Frequency	Once every 12 months
<ul style="list-style-type: none"> Exam/Lenses/Frame 	
Copayments	\$15 Exam* \$25 Materials* \$15 Contact Lens Fitting (CLF) Exam**
Exam	Covered in full
Lenses – Covered in full	Single, Lined Bifocals, Lined Trifocals, Lenticular
Covered Lens Options <i>(if no lens options are outlined, then there is no coverage, only member preferred pricing discounts available in-network)</i>	Polycarbonate lenses for dependent children Tints and photochromic lenses Progressive lenses up to \$165
Frame Allowance	\$125 Retail
Elective Contact Lenses*** <i>(material co pay does not apply. Allowance is applied to materials)</i>	\$130
Out-of-Network Reimbursement	
Exam	Up to \$34 (Ophthalmologist) Up to \$26 (Optometrist)
Single Vision	Up to \$29
Bifocal	Up to \$43
Trifocal	Up to \$53
Frame	Up to \$65
Elective Contact Lenses***	Up to \$100
Discounts	
Add-ons to covered pair of lenses	20%
Additional purchases of eyeglasses	30%
Additional purchases of contacts	10-20%
Refractive surgery (RK, PRK, LASIK)	20%

*Copayment will be deducted from out-of-network reimbursement

**Specialty CLF exam maximum benefit up to \$50; CLF exam not covered out-of-network

***Contact lenses in lieu of eyeglasses

This is only a summary of your vision benefit plan. Please refer to the certificate of coverage available at www.cbizesc.com/kckps for plan details.

▮ FLEXIBLE SPENDING ACCOUNTS ▮

CBIZ, INC.

A great way to plan ahead and save money over the course of a year is to participate in the Flexible Spending Account (FSA) programs. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay medical expenses which are not reimbursed by your insurance plan or to pay for dependent care expenses.

Pre-tax means the dollars you use for eligible expenses are not subject to social security tax, federal income tax, and state and local income tax. Money you would have paid in taxes can be used to pay for qualified expenses.

There are two ways to maximize your pre-tax savings:

- The Healthcare Account
- The Dependent Care Account

***Don't Forget the
*Use it or Lose it Rule!****

HEALTHCARE ACCOUNT

You may elect to contribute up to \$2,500 each plan year. **However, due changes in the USD #500 benefits plan year, the maximum healthcare contribution amount is \$1,250 for the July 1, 2012 – December 31, 2012 benefit period.** Eligible expenses that can be paid from this account are those not covered by your medical, dental, and/or vision plans.

Some examples include:

- Plan deductibles, copayments, and other out-of-pocket costs
- Vision services, such as contact lenses, eye exams, eyeglasses and laser eye surgery
- Prescription expenses

For a complete list of eligible expenses, log onto www.cbizesc.com/kckps and from the main menu select "Section 125 Plan", then select "Qualifying Expenses".

The IRS does not allow the following expenses to be reimbursed under the Healthcare Account: (the list below includes some of the more common items and is not meant to be all-inclusive):

- Cosmetic surgery/procedures
- Electrolysis
- Hair loss medication
- Health club dues
- Herbs & herbal medicines
- Teeth whitening/bleaching



DEPENDENT CARE ACCOUNT

You may contribute up to \$5,000 or up to \$2,500 if you are married and file separate tax returns. **However, due changes in the USD #500 benefits plan year, please note for the July 1, 2012 – December 31, 2012 benefit period the maximum dependent care contribution amount is \$2,500 or up to \$1,250 if you are married and filing separate tax returns.** Eligible dependent care expenses are for the care of children under age 13 or dependents of any age that are unable to care for themselves because of mental

or physical handicap. The services must be necessary to allow you, or you and your spouse if you are married, to work or attend full-time school.

REIMBURSEMENTS

Some important things to remember about flexible spending accounts:

- You are responsible for filing claims for reimbursement.
- You may elect to have reimbursements mailed to your home or deposited directly in your personal account.
- You may access the website www.myflexonline.com at any time for current account information.
- You may elect to use the free debit card for healthcare reimbursement, which may allow you to avoid filing claims. It is important that you keep your receipts on file.



- Your debit card is accepted at only qualified locations, such as pharmacies, doctor's offices, vision care centers, and hospitals. These IRS-imposed limitations help to insure that the card is used only when paying qualified expenses.
- You can avoid having to verify card purchases by using a retail partner such as CVS, Wal-Mart, Walgreens or Drugstore.com. Only retail partner systems allow qualified purchases to be charged on the debit card.
- Certain card swipes can be automatically verified. However, if the total amount of a card swipe cannot be matched with your co pays, the IRS requires that all details be verified.
- Failure to send in requested documentation could result in suspension of your debit card and you may be required to pay-back the plan.

IMPORTANT RULES

In exchange for the tax advantages, the IRS has strict rules about how these accounts must work.

- You may not stop or change your contribution amounts until the next Open Enrollment, unless you have a qualifying status change.
- Any funds remaining in the accounts at the end of the plan year grace period are forfeited. "Use it or lose it."
- The Healthcare Account and Dependent Care Account function separately; funds may not be transferred from one to the other.
- The money you contribute to each account for the plan year can only be used for eligible expenses you incur during that same plan year.
- Expenses for the July 1, 2012 – December 31, 2012 plan year must be incurred by March 15, 2013 and submitted by March 31, 2013.



▮ VOLUNTARY INSURANCE ▮

UNUM – VOLUNTARY GROUP TERM LIFE INSURANCE

For your peace of mind and the financial protection of your family, USD #500 offers group term life coverage through UNUM. If you decline voluntary life insurance when first eligible, or if you elect coverage and wish to increase your benefit amount at a later date, evidence of insurability may be required.

FOR YOURSELF

Choose from one to five times your annual earnings in increments of \$10,000 (not to exceed \$500,000).

FOR YOUR SPOUSE

Coverage must be purchased in increments of \$5,000 and cannot exceed \$250,000 or half the amount you purchase for yourself, whichever is less.

FOR CHILDREN

Coverage must be purchased in increments of \$2,000 not to exceed \$10,000 or half the amount you purchase for yourself, whichever is less.

BENEFICIARIES

Your beneficiaries are the people or institutions you name to receive your life insurance benefits in the event of your death. You are the beneficiary for your spouse and/or children. It is important to keep up-to-date beneficiary information on file. Please contact the Benefits Office to change your beneficiary.

Reminder, KPERS includes a life insurance benefit of 150% of your salary.



UNUM – VOLUNTARY SHORT TERM DISABILITY

Should a sickness or injury strike, your out-of-pocket expenses – not to mention lost time on the job – can impact the financial well-being of you and your family. UNUM's voluntary individual short-term disability insurance can help replace a portion of your salary in the event of a covered sickness or off-the-job accident.

- Secures up to 60% of your gross salary (not to exceed \$5,000 monthly).
- You choose how much coverage you want – between \$400 and \$5,000.
- Your premiums are based on your age when you buy the insurance and will not increase as you get older
- Benefits are payable after a 14-day elimination period and you can receive benefits for up to 6 months. (KPERs include a long-term disability benefit after a 6 month waiting period.)
- If you leave employment or retire, you can take the policy with you and pay the same premium. UNUM will bill you directly at home.

PRE-EXISTING CONDITION LIMITATION

A pre-existing condition is defined in your policy as a condition for which symptoms existed that would cause you to seek treatment from a physician, or took medicine within 12 months before your coverage effective date. Benefits for a disability due to a pre-existing condition will not be paid if that disability begins within 12 months of your coverage effective date. Pregnancy, at the time coverage is effective, is considered a pre-existing condition. For more information about pre-existing conditions, please email benefits@kckps.org.



UNUM – VOLUNTARY SPECIFIED CRITICAL ILLNESS INSURANCE

The critical illness plan pays a lump sum benefit upon the initial diagnosis of a covered illness such as heart attack, stroke, or cancer. Plan benefits may be used for any purpose you choose. You may elect to use these benefits to help pay the non-medical costs associated with catastrophic illnesses such as lost wages, rehabilitations, family care and transportation. You may purchase coverage for yourself and your family and may choose an amount from \$5,000 to \$50,000.

You may be required to complete Evidence of Insurability if you elect coverage after your initial eligibility period has expired or if you increase your coverage past the guarantee issue limit. You are eligible the Open Enrollment following your date of hire.

▮ How to Enroll ▮

ACTIVE EMPLOYEES

Enrolling on the web is fast and easy! Follow the steps below to make your plan selections:

1. Complete the Enrollment Worksheet that was given to you with this book. This will ensure that you have made all the necessary decisions prior to enrolling online.
2. Go to the enrollment website at www.cbizesc.com/kckps.
3. Enter your Employee ID Number (4 or 5 digits) found on your paystub.
4. Enter your PIN – if you've never been to the site or if you've not change your PIN, enter your date of birth mmddyyyy.
5. Click "Login."
6. You can begin making your plan selections by clicking "Enroll/Change Your Benefits" and then selecting the "Plan Year 2012."
7. Follow the online instructions to enroll.
8. Once you've completed your enrollment, a confirmation statement will appear. PRINT this page for your records.
9. Click "Confirm". You will then receive a confirmation number. PRINT this page for your records.

Your enrollment is not complete until you have a confirmation number!



ENROLLING IN UNUM SHORT TERM DISABILITY AND CRITICAL ILLNESS

- Available only during the open enrollment period.
- Please follow the instructions on the enrollment site, www.cbizesc.com/kckps.

NEW RETIREE INFORMATION

If you are retiring from USD #500 and are eligible for KPERS, you may be eligible to continue your medical, dental, and/or vision benefits as a retiree. To continue your benefits, please follow these guidelines:

- Before you retire, check with the Benefits Office to see how long your active employee benefits continue.
 - For example, if your retirement date is September 1 and you receive paychecks through August 31, your active employee benefits will end September 30. You will not start your retiree benefits until October 1.
- **Make sure you re-enroll during the May Open Enrollment.** If you do not re-enroll, you may lose your right to continue your coverage under the retiree program and under COBRA.
- USD #500 uses a vendor called CBIZ COBRA to administer the retiree benefits. After the Benefits Office receives notification that you are retiring, they will submit notification to CBIZ COBRA.
 - CBIZ COBRA will notify you in writing of your rights to continue your benefits with instructions on how to transfer your enrollment status from active to retiree.
 - All communication regarding your status transfer must be made with CBIZ COBRA.
 - All payments must be made to CBIZ COBRA.
- Once CBIZ COBRA receives your continuation paperwork with payment, they will notify the Employee Service Center, USD #500's online enrollment vendor.
 - The Employee Service Center transfers your status and submits to the insurance carriers on a weekly basis. Please be aware that there may be a delay in transferring your coverage.
 - For example if your coverage as an active employee ends July 31, and you do not return your form until the 60 day deadline has almost expired (September 29), your coverage lapsed for almost 2 months. There may be an additional 10-14 day delay to turn your coverage back on. You may be required to pay for services (including prescriptions) until your coverage is turned back on. You may then submit a claim for reimbursement.
- **IF YOU DO NOT RETURN YOUR FORM AND PAYMENT ON TIME TO CBIZ COBRA, YOU WILL NOT HAVE RETIREE COVERAGE.**
- After CBIZ COBRA receives your initial enrollment paperwork, you will receive payment coupons (if you do not elect Auto pay).
- USD #500 enforces a strict payment policy:
 - All payments must be postmarked by the last day in which they are due.
 - For example, the March payment must be postmarked by March 31.
 - If a check is returned for insufficient funds, you must repay the amount within 31 days by a cashier's check or money order. All future payments must be made by Auto pay.
 - CBIZ COBRA offers all retirees the option to pay automatically each month through Auto pay. Auto pay is convenient and payments are never late.
 - Your first late payment will result in cancellation.
- Retirees must re-enroll each year for benefits. You will receive your re-enrollment packet by US Mail, and your worksheet must be returned to CBIZ COBRA by the date specified.

Medical coverage ends for retirees at age 65. Dental and vision coverage can be continued beyond age 65. If you are over 65 at retirement, you will be offered COBRA for medical coverage (if applicable) and retiree status for dental and vision (if applicable).

If you have any questions prior to retiring, please contact the Benefits Office at 913-279-2274 or 913-279-2135 or via email at benefits@kckps.org.

▮ NON-RETIREMENT RESIGNATIONS ▮

To continue your benefits, please follow these guidelines:

- Before you resign, check with the Benefits Office to see how long your active employee benefits continue.
 - For example, if your resignation date is September 1 and you receive paychecks through August 31, your active employee benefits will end September 30.
- **Make sure you re-enroll during the May Open Enrollment.** If you do not re-enroll, you may lose your right to continue your coverage under COBRA.
- USD #500 uses a vendor called CBIZ COBRA to administer the COBRA benefits. After the Benefits Office receives notification that you are leaving the District, they will submit notification to CBIZ COBRA.
 - CBIZ COBRA will notify you in writing of your rights to continue your benefits.
 - All communication regarding your benefits must be made with CBIZ COBRA.
 - All payments must be made to CBIZ COBRA.
- Once CBIZ COBRA receives your continuation paperwork with payment, they will notify the Employee Service Center, USD #500's online enrollment vendor.
 - The Employee Service Center submits information to the insurance carriers on a weekly basis. Please be aware that there may be a delay in transferring your coverage.
 - For example if your coverage as an active employee ends July 31, and you do not return your form until the 60 day deadline has almost expired (September 29), your coverage lapsed for almost 2 months. There may be an additional 10-14 day delay to turn your coverage back on. You may be required to pay for services (including prescriptions) until your coverage is turned back on. You may then submit a claim for reimbursement.
- **IF YOU DO NOT RETURN YOUR FORM AND PAYMENT ON TIME TO CBIZ COBRA, YOU WILL NOT HAVE COBRA COVERGE.**
- After CBIZ COBRA receives your initial enrollment paperwork, you will receive payment coupons.
- USD #500 enforces a strict payment policy:
 - All payments must be postmarked by the last day in which they are due.
 - For example, the March payment must be postmarked by March 31
 - Your first late payment will result in cancellation.
- COBRA members must re-enroll each year for benefits. You will receive your re-enrollment packet by US Mail, and your worksheet must be returned to CBIZ COBRA by the date specified.

Please refer to page 28 for additional COBRA information.

HIPAA Privacy Notice ¶

NOTICE OF PRIVACY PRACTICES

The USD #500 Kansas City, Kansas 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 Connie Brand at 913-551-3200.*

If you would like to pursue any of your individual rights regarding your PHI, contact Dr. Kelli Mather, 2010 N 59th Street, Kansas City, KS 66104, 913-551-3200. 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 became 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 USD #500, Kansas City, Kansas Public Schools, 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: USD #500 Business Office – Attn: Benefits. 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

USD #500, Kansas City, Kansas Public Schools
Connie Brand, Director of Finance, Treasurer
2010 N 59th Street
Kansas City, Kansas 66104
(913) 551-3200

Medicare Part D Notice

Important Notice from USD #500 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 USD #500 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. USD #500 has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Kansas City is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current USD #500 coverage may be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. Please refer to USD # 500 District website at www.kckps.org for the plan summary describing your prescription benefits.

If you do decide to join a Medicare drug plan and drop your current USD #500 coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with USD #500 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 USD #500 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:	March 30, 2012
Name of Entity/Sender:	USD # 500 Kansas City Kansas Public Schools
Contact--Position/Office:	Connie Brand- Director of Finance
Address:	2010 N. 59 th Street Kansas City, Kansas 66104
Phone Number:	913-551-3200

▮ DEFINITIONS ▮

Annual Maximum – For all dental services, other than orthodontia, there is a maximum benefit that the plan will pay each calendar year per individual. Once this maximum is reached, no further benefits will be payable during the calendar year.

Brand Name Formulary Drug (Tier 2) – A list of preferred brand name drugs have been approved by Blue KC's physician and pharmacist advisors. Brand name formulary drugs are selected based on their success in effectively treating certain conditions, as well as their relative cost-effectiveness.

Brand Name Non-Formulary Drug (Tier 3) – These are brand name drugs not on Blue KC's preferred list. Your share of the cost is greatest when you purchase a brand name non-formulary drug because it is not as cost-effective for the plan.

Deductible – The deductible is the amount of your covered expenses you must pay each calendar year before the plan begins to pay.

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

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). Hospital copayments for the HMO plan will apply to the out-of-pocket maximum. Copayments do not apply to the out-of-pocket maximum on the PPO plans.

Fee Schedule (applies to the dental low PPO) – The plan will not pay for any charge above the network provider fee schedule when you receive covered services from out-of-network providers. Fee schedule refers to a fixed cost that is negotiated between the plan and the network dentist. If your service with an out-of-network provider exceeds the fee schedule, the provider could bill you for the excess. Because in-network providers charge agreed upon rates, you will never exceed fee schedule charges when you use in-network providers and cannot be billed for the excess above your regular coinsurance.

In-Network – In-network coverage is provided for covered expenses when you receive treatment of services from a physician or hospital which is a member of the network specific to your plan.

Out-of-Network – Out-of-network coverage is provided for covered expenses incurred when you receive treatment or services from a physician or hospital which is not a member of the network specific to your plan. The plan considers covered expenses only up to Reasonable and Customary (R&C) limits. The HMO plan typically provides out-of-network coverage only for emergency room services for true emergencies.

Out-of-Pocket Maximum – This maximum limits your medical out-of-pocket expenses (including deductibles 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. On the PPO plans, only deductible and coinsurance apply to the out-of-pocket maximum. On the HMO plan, coinsurance and hospital copayments apply.

Primary Care Physician (PCP)

The physician who a member chooses as his or her primary physician for medical care. Primary care physicians typically specialize in one of four fields of medicine: family practice, general practice, internal medicine or pediatrics. HMO members are required to have a PCP on file.

Reasonable & Customary (applies to the medical plans & the dental high PPO) – The plan will not pay for any charge above the Reasonable and Customary (R&C) limit when you receive services from out-of-network providers, and these charges do not apply towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services and supplies in your geographic area. If your service with an out-of-network provider exceeds R&C, the provider may bill you for the excess. Because in-network providers charge agreed-upon rates, you will never exceed R&C charges when you use in-network providers.

Special Limitation (dental only) – Teeth lost or missing before a covered person becomes insured by the plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he/she became insured by the plan. The plan will not pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person becomes insured by the plan.

Specialist

Doctors of medicine (MD), osteopathy (D.O.) and other medical practitioners who specialize in a particular branch of medicine. For example a cardiologist, allergist or OB GYN.

▮ IMPORTANT CONTACTS ▮

Before You Enroll

If you have questions regarding the enrollment process or the benefit plans and you have not yet enrolled, please contact the Benefits Office at 913-279-2274 / 913-279-2135 or email at benefits@kckps.org.

After You Enroll

Once you have enrolled in the group benefit plans and voluntary benefit plans, making use of the benefits can sometimes be a challenge. We encourage you to call the carrier first for questions you may have.

Blue Cross Blue Shield of Kansas City (Medical)

816-395-3777 or 1-866-811-4589

Website: www.bluekc.com

Guardian (Dental)

1-800-541-7846

Website: www.Guardianlife.com

Superior Vision (Vision)

1-800-507-3800

Website: www.Superiorvision.com

CBIZ, Inc. (Flexible Benefits Administrator)

1-800-815-3023, option 4

Claim forms can be mailed or faxed to: *Please keep a copy for your records*

CBIZ Payroll, Attn: Flex, 310 First Street, Suite 600, Roanoke, VA 34011

Fax: 1-800-584-4185

Website: www.myflexonline.com

UNUM (Group Voluntary Life, Short Term Disability, Critical Illness)

Website: www.Unum.com

Group Voluntary Life

1-800-421-0344

Short Term Disability/Critical Illness

1-800-635-5597

CBIZ BENEFITS COORDINATOR

JaNia Motley

913-279-2135

benefits@kckps.org

Have questions about your medical, dental, vision, flexible spending accounts, and voluntary life, disability and critical illness coverage? As a first step, please contact the insurance carrier directly as they are the best resource for your specific information. If you have questions or concerns after that call, please feel free to contact me.

Please contact the Benefits Office at 913-279-2274/ 913-279-2135 or email at benefits@kckps.org with additional questions or concerns.