

Welcome to your 2025 Benefit Guide

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November 2024



Dear USD #265 Goddard Employees:

You are a valued and integral part of the continued success of our school. We recognize the importance of your family's financial security and will continually strive to offer a complete benefits package.

This booklet is designed to give an overview of our benefit plans. The benefits offered include Medical, Dental, Vision, Voluntary Life and AD&D, Voluntary Short-Term Disability, Flexible Spending Accounts (Medical & Dependent Care), Accident and Critical Illness and an Employee Assistance Program. I hope you find this booklet useful and will participate in the benefits to the fullest extent possible.

The district is again working with Blue Cross and Blue Shield of Kansas (BCBSKS). The district has worked with our benefits advisors at Gallagher along with BCBSKS to manage the increase by making some adjustments to the plan. Please read the Medical and Dental Options portion of the handbook for more information.

Regarding the other insurance options, in most cases there was no premium increase this year. This includes the various life/accident policies through Mutual of Omaha.

All benefits offered are "a la carte" - you have the ability to pick and choose which benefits best meet you and your families' needs. If you have any questions regarding these plans, please contact Gallagher Benefit Services at (316) 977-9779.

Sincerely,

Doug Maxwell

Doug Maxwell CFO

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 45-46 for more details.



USD 265 Goddard provides a wide range of employee benefits for you and your dependents. We encourage you to thoroughly evaluate your needs and the needs of your family before enrolling or declining to participate in any of the benefit plans. This Benefit Guide contains an overview of some elements of the employee benefit plans we sponsor.

This Guide is intended to provide a summary of the main features of our benefits package. It is much shorter and less technical than the legal documents and contracts governing our benefits. We have made every effort to make sure this information is accurate; however, in the case of any discrepancy, the provisions of the legal plan documents and insurance certificates will govern. Our benefit information is also available on our benefit website: http://c2mb.ajg.com/usd265goddard/home/ Each benefit plan may be amended or terminated at the sole discretion of USD 265 Goddard. Nothing in this benefit guide is intended to guarantee employment of any employee.

If you do not enroll at your first opportunity, <u>you may not be able to enroll until the next annual open enrollment period.</u> Since your premiums are paid through a Section 125 Cafeteria Plan, you cannot terminate coverage until the end of the plan year unless you terminate employment or if you have a qualifying family event. If you have questions, please contact our benefit consultant: Arthur J. Gallagher & Co. at (316) 977-9779.

Important Information

Open Enrollment

Open Enrollment is the one time per year you may start, stop or change your benefit elections. Any requests after Open Enrollment to change your benefit elections and who is insured must be due to a covered Qualifying Life Event.

2025 Open Enrollment

October 21st through November 4th, 2024



Qualifying Life Events

After your initial eligibility date and other than the annual open enrollment period, you may only change your benefit election and covered dependents within 30 days following a Qualifying Life Event including:

- Birth or adoption of a dependent child;
- Marriage, legal separation, annulment, or divorce;
- Death of spouse and/or dependent;
- Dependent's loss of eligibility;
- Termination or commencement of spouse's employment with health care coverage offered or open enrollment;
- Employee or spouse's eligibility for Medicare



You must notify the Human Resources within 30 days of a qualifying event to make changes after your initial eligibility date.

Who is Eligible?

Employee

All active, full-time employees working 30 or more hours per week are eligible to enroll. Employees assigned and working 20 - 29 hours per week are eligible to enroll in all offered coverages with the exception of medical insurance and the Health Care Spending Account. New employees are eligible the first of the month following 30 days.

Dependents

As an employee eligible to enroll in the group insurance plans, you may elect certain options for your dependents. Eligible dependents include:

- Your legal spouse;
- Your dependent child or step child up to age 26 for the medical, dental and vision plans;
- Any child placed with you for adoption or for whom you have legal guardianship;
- Any unmarried, disabled child of any age who resides with you, medically certified as disabled prior to his/her 26th birthday and primarily dependent upon you for support;
- Any eligible child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.



Important Information

Healthcare Reform

Due to Healthcare Reform:

- The individual mandate became effective on 01/01/2014
- For tax year 2025, if you don't have coverage the fee/penalty no longer applies. This is subject to change if different legislation is passed.

Healthcare Reform Exchanges:

- If you are eligible for benefits at the USD 265
 Goddard and buy coverage through a Federal or
 State Exchange- you and your family will not
 qualify for a subsidy through the Exchange.
- Federal and State Medicaid programs offer low cost or free medical coverage to individuals and families with limited incomes. Your eligibility will depend on your state, income, and family size.
 For more info visit: www.healthcare.gov.

Summary of Benefits & Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare options. The SBC is available on the web:



Benefits Disclaimer

The benefits shown in this guide are only a summary of the benefits and do not include all the plan's limitations, exclusions, preauthorization requirements and conditions of coverage. Not all services are covered by your health plan. Refer to your plan's summary plan description, insurance company's master policy or certificate of insurance for a complete description of covered benefits.

Your health plan has negotiated fee discounts with some health care providers. These providers have several names including contracting providers, preferred providers, network providers or participating providers. The contracting providers discounted price is called the "allowed amount". When you receive your health care from contracting providers, you will receive the highest benefits allowed by your plan. In addition, the contracting providers agree not to balance bill you the amount of the discount. It is your responsibility to verify your providers are contracting providers for your health plan.

Non-contracting providers set their own fees and do not offer a discounted fee to your health plan. Their fees are usually higher, sometimes much higher, than your health plan's allowed amount. Non-contracting providers will also require you pay the difference between their fee and the health plan's allowed amount. This difference can be substantial and may not satisfy your deductibles, coinsurance, copays or out of pocket limits shown in this guide.

If you have questions about contracting providers or your benefits, contact your claims payer or insurance company for more information.

Online Enrollment Sign-On Instructions

2025 Open Enrollment is available from October 21st through November 4th, 2024.

Your 2024 benefit elections will automatically rollover to 2025 EXCEPT any Flexible Spending Account Elections.

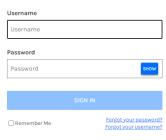
If you do not login and review your benefits at open enrollment, your elections will remain the same EXCEPT your FSA enrollment will be \$0.00 for the 2025 plan year.

(1)

Login to ARCORO/INFINITY HR site

- Go to https://identity.arcoro.com/Account/Login
- Choose the box on the left (Benefits) and click the arrow
- Log In with your User ID and Password.
- If don't remember it, click "Forgot you password/username"

ARCORO



2

Homepage

- Review Homepage
- Under Change Events, the dropdown should say "Open Enrollment.".
- Click "Begin Event"

You have started, but not yet completed, the Event displayed in the dropdown box below. You must eithe complete or cancel this Event to access other Events. Events Available: Open Enrollment Begin/Continue Event Reset and Begin Event Statements Start End View Benefit Statement Op(01/2021



Complete Enrollment

- Click through both Authorization screens.
- Confirm info for yourself and then for your spouse and/or children.
- Go through each benefit screen by clicking "SAVE & CONTINUE" once your elections have been made.

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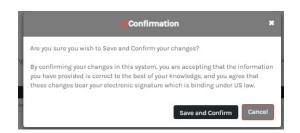
Enter Beneficiaries

- Select a Primary Beneficiary for each benefit. If you need to add a beneficiary, click "Add Beneficiary" and complete the information. You can add multiple beneficiaries; however, the total percentage must equal 100%.
- Repeat if you choose to enter a Contingent Beneficiary. If not, leave "Primary" clicked and enter 0.
- When finished, click "Save and Continue".

5

Review and Confirm

- Review information on Review Step. If you selected a benefit that requires Evidence of Insurability (EOI), you will need to print, complete and return the form to HR.
- Click "Save & Continue" button to confirm your enrollment. A popup will appear asking if you are sure.
- On the next page, you can Print Confirmation Statement.
- You can log in & make changes until the close of Open Enrollment.



^{*}To access this system you must have a valid account created for you and have a valid email address on file.

Tips to Save Money on Health Care

Be Smart - If your employer offers two or more medical plans, learn what your out of pocket cost will be for each plan and how much each plan will cost you. Then choose the plan best meeting your needs. You might be throwing money away by choosing the wrong medical plan.

Choose Healthy - Some companies are encouraging employees to take better care of themselves by eating a healthier diet and exercising.



Communicate - Call your primary care physician if you need medical attention and it is not life or limb threatening. After explaining your condition, your doctor may be able to call in a prescription or provide some other remedy. Many physicians will talk with you on the phone if you are an established patient and get annual check ups.

Prevention - An annual routine physical might save

your life and a bunch of money. An annual checkup allows your doctor to run lab tests to see if you have any health issues.



Stay In-network - Most health plans offer both inand out-of-network benefits. You will pay more for seeing an out-of-network doctor or going to an outof-network facility.

Free Advice - Pharmacists know a lot about prescription drugs, so talk to yours about the drugs you take. Your pharmacist might be able to suggest a less expensive alternative you can ask your physician about and save money.



Stop smoking - In addition to the cost of cigarettes, smokers on average incur six times the amount of health expenses versus a non-smoker.



Generic Rx - Talk to your doctor or pharmacist about switching from brand name drugs to generic drugs. More and more generics are available each year and usually cost less too.

Urgent vs Emergency -Consider going to an Urgent Care Center instead of the Emergency Room. Urgent Care Centers are similar to doctors offices and much less expensive.



Stretch with Flex - Does your employer offer Flexible Spending Accounts through a Section 125 Cafeteria

Plan? If yes, you will be able to stretch your money farther because you do not pay taxes on the amount of salary



you convert to non-taxable benefits. You will save taxes on medical, dental, vision or drug expenses that are predictable.

Over There - If medical coverage is available where your spouse works, you might save money by splitting your coverage between both employers. Many employers pay a higher percentage of the premium for single coverage.

Medical Plans

Administered by BCBS of KS

	\$1,500 F	PPO Plan	\$3,500	PPO Plan	\$5,000 HDH	P PPO Plan	
Benefit Period (January 1, 2025 thru December 31, 2025)	Plan	Year	Plan Year		Plan Year		
Deductible (per plan year)		er person er family	\$3,500 per person \$7,000 per family		\$5,000 per person 10,000 per family		
Coinsurance (member pays)	50	0%	5	50%	Nor	ne	
Out-of-Pocket Maximum Maximum deductible, coinsurance & copays (medical & prescription) per plan year	\$6,350 ir \$12,700 p	ndividual per family		individual per family	\$5,000 individual \$10,000 per family		
Office Visits							
Primary Care Physicians	\$35 (сорау	\$35	сорау	\$0 copay afte	r deductible	
Specialists	\$70	copay	\$70) сорау	\$0 copay afte	r deductible	
Telemedicine	\$0 c	сорау	\$0	copay	\$0 copay afte	r deductible	
Routine Eye Exam (Optometrist Refraction)	\$35 (сорау	\$35	сорау	\$0 copay afte	r deductible	
Outpatient Lab and X-ray Services (imaging; MRI, CT scans, PET scans)	Subject to	ded/coins	Subject to ded/coins		Subject to deductible		
Preventive Services (see certificate)	Covered	at 100%	Covered at 100%		Covered at 100%		
Emergency Services							
Urgent Care Center	\$50 (сорау	\$50 copay		\$0 copay afte	\$0 copay after deductible	
Hospital Emergency Room	\$250 copay	, then 50%*	\$250 copay, then 50%* \$0 copay after de		r deductible		
Lifetime Benefit	Unlir	nited	Unl	imited	Unlimited		
Prescription Drugs							
Generic drugs	\$15 0	сорау	\$15	copay	\$0 copay afte	r deductible	
Preferred brand drugs	\$40 c	сорау	\$40	copay	\$0 copay after deductible		
Non-preferred brand drugs	\$75 c	сорау	\$75	copay	\$0 copay after deductible		
Specialty drugs**	Preferred: Non-Preferre	\$40 copay ed: \$75 copay	Preferred: \$40 copay Non-Preferred: \$75 copay		\$0 copay afte	r deductible	
Payroll Deductions	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly	
Employee Only	\$193.98	\$96.99	\$161.62	\$80.81	\$135.34	\$67.67	
Employee & Spouse	\$686.58	\$343.29	\$628.10	\$314.05	\$581.30	\$290.65	
Employee & Child(ren)	\$551.14	\$275.57	\$500.02	\$250.01	\$458.76	\$229.38	
Family	\$951.36	\$475.68	\$879.32	\$439.66	\$820.82	\$410.41	

Defined Benefit: Full time employees working 30 or more hours per week are eligible to receive a defined board paid fringe benefit of \$425 per month to be paid towards a medical plan of their choice. The rates listed above are the true monthly or bi-weekly employee cost, the \$425 fringe benefit has already been deducted.

^{**}For more information about limitations and exceptions, see the plan or policy document at www.bcbsks.com.

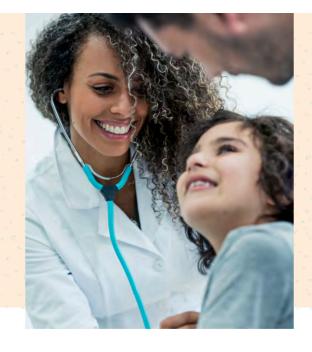


^{*}After the Annual Medical Deductible has been met.

Preventive services

Preventive services

The items listed below are services that some consumers can receive without any cost-sharing, meaning they will not pay deductibles, copays or coinsurance for the preventive services outlined. Preventive services must be provided by an eligible contracting provider as outlined in the member benefit description. **Preventive services are subject to change.**



Preventive services for adults

- Abdominal aortic aneurysm screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Behavioral counseling to promote a healthy lifestyle in adults with cardiovascular risk factors
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk, and coverage for certain statins in adults 40-75 years old at increased risk of cardiovascular disease
- Colorectal cancer screening for adults 45-75 years old
- Depression screening for adults
- Type 2 diabetes screening for adults aged 35-70 who are overweight or obese
- Diet counseling for adults with high cholesterol, cardiovascular disease and diet-related chronic disease
- Counseling adults with fair skin types to reduce risk of skin cancer
- Exercise interventions to prevent falls in certain adults at increased risk for falls

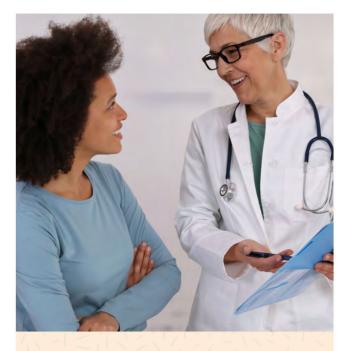
- Hepatitis B virus infection screening in persons at high risk of infection
- Hepatitis C virus infection screening for adults at higher risk
- HIV pre-exposure prophylaxis (PrEP) for persons who are at high rist of HIV acquisition
- HIV screening for all adults at higher risk
- Lung cancer screening of adults of increased risk
- Routine immunizations for adults doses, recommended ages and recommended populations vary
- · Obesity screening and counseling for all adults
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculin screening in adults of increased risk
- Unhealthy drug use screening via questionnaire (does not include testing biological specimens)

Preventive services

Preventive services for women including pregnant women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- Behavioral counseling interventions for healthy weight and weight gain in pregnancy
- Breast cancer genetic test (BRCA) counseling for women at higher risk for breast cancer
- Breast cancer mammography screenings
- Breast cancer chemopreventation counseling for women at higher risk and providing of coverage for certain drugs taken for chemopreventation
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical cancer screening
- Chlamydia infection screening for sexually active younger women and other women at higher risk
- Contraception select contraceptive methods, sterilization procedures, and patient education and counseling, including emergency contraceptives
- Counseling interventions for pregnant and postpartum persons at increased risk of perinatal depression
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at increased risk

- Hepatitis B screening for pregnant women at their first prenatal visit
- Human immunodeficiency virus (HIV) screening and counseling for women of higher risk
- Human papillomavirus (HPV) testing every three years for women who are 21 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women
- Screening for preeclampsia in pregnant women and coverage for low-dose aspirin in women after 12 weeks gestation who are at high risk of preeclampsia



Stay informed

For more information on health care and preventive services, please visit healthcare.gov.

Preventive services

Preventive Services for Children

- Congenital hypothyroidism screening for newborns
- Counseling of children and adolescents with fair skin types to reduce risk of skin cancer
- Fluoride supplementation for children without fluoride in their water source
- Fluoride varnish for infants and children
- Gonorrhea preventive medication for the eyes of all newborns
- Hematocrit or hemoglobin screening for children
- HIV screening for adolescents at higher risk
- Interventions to prevent initiation of tobacco use among school aged children and adolescents
- Iron supplements for children of certain ages at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Phenylketonuria (PKU) screening in newborns
- Sickle cell screening for newborns
- Screening for major depressive disorder in adolescents
- Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at increased risk of tuberculosis

Preventive Services for Children: **Bright Future Recommendations***

- Alcohol, drug and tobacco use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
- Height, weight and body mass index measurements for children
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary
- Oral health assessment for young children
- Vision screening

*Bright Futures is a national health promotion and preventive initiative, led by the American Academy of Pediatrics.

This is a summary of preventive services — it is not a legal document. Preventive services are subject to change. The exact provisions of the benefits and exclusions are contained in the certificate.

Visit us at bcbsks.com





















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An independent licensee of the Blue Cross Blue Shield Association

FlexAccess

FlexAccess™

Specialty Copay Solution

Save money on your high-cost medicines

Medicines for long-term health conditions can be expensive and hard to get when and where you need them.

FlexAccess is here to help. Blue Cross and Blue Shield of Kansas has partnered with FlexAccess to find the best copay assistance (coupon) discounts for you — meaning your medicines may be cheaper and easier to get.

Enrollment

When purchasing certain drugs, you will be contacted by a FlexAccess team member by phone to register you in the drug manufacturer's copay assistance program to minimize your out-of-pocket expense. If you choose not to register with FlexAccess, you may be responsible for your copay without assistance.

Please note that some manufacturers do not allow FlexAccess to enroll you in the manufacturer copay assistance program on your behalf. If FlexAccess is unable to complete the enrollment on your behalf, they will provide you with the information necessary for you to self-enroll in the copay assistance program. Once you have self-enrolled, you will be asked to share your copay assistance information with your pharmacy.



Here are some great benefits you'll gain when utilizing FlexAccess.

- **Savings:** Your copays (what you pay for medicine at the pharmacy) will almost always be \$0–\$35.
- Peace of mind: What you pay for your purchases through FlexAccess will count toward your deductible (what you pay before your plan starts paying). They will also count toward your out-of-pocket maximum (the most you pay in a plan year).

Visit us at bcbsks.com



















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Prime Therapeutics LLC is an independent company that provides pharmacy benefit management services. Blue Cross and Blue Shield of Kansas, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

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Blue365





FOR YOUR EMPLOYEES

Did you know that, as Blue Cross and Blue Shield members, your employees have access to exclusive discounts on gym memberships, wearables, weight loss programs and more? With Blue365, you can help make it easier and more economical for your employees to workout, eat healthy, and live well. Blue365 offers the best discounts from top brands including:

















ENHANCED PERKS AT NO-COST WITH BLUE365:

- > All members need to do is register at https://www.blue365deals.com/user/register
- > Share this registration link with your employees so they can start saving today

CHECK OUT:

https://www.blue365deals.com/ employer-solutions

for more information on how Blue365 can support your organization with bulk discounts



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Blue365 offers access to savings on health and wellness products and services and other interesting items that Members may purchase from independent vendors, which are not covered benefits under your policies with your local Blue Company, its contracts with Medicare, or any other applicable federal healthcare program. These products and services will be offered to you through the entire benefit year. During the year, the independent vendors may offer additional discounts on these products and services. To find out what is covered under your policies, contact your local Blue Company. The products and services described on the Site are neither offered nor guaranteed under your Blue Company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Company's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the Site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product or service available under or through the Blue365 Program or Site.

Eat your way to better health







If you struggle with diabetes or high blood sugar, your body may be carbohydrate intolerant. Virta's remote medical team and health coaches can teach you how to change the food you eat so you can naturally lower your blood sugar. Imagine less insulin, weight loss, and better sleep. This is life on Virta. Virta treatment is backed by clinical research and cited by the American Diabetes Association.



- Lose weight
- Lower blood sugar
- Decrease medications
- Reduce A1c

How is Virta different?

- No calorie counting
- No exercise
- No surgery
- No office visits

Care tailored to your needs and lifestyle

Blue Cross and Blue Shield of Kansas fully covers the cost of Virta (valued at over \$3,000) for eligible members with type 2 diabetes.

What's the cost?

Pay no extra fees if you meet the requirements. Your test supplies are covered too.

Learn more

virtahealth.com/join/bcbsks



Virta is available to Blue Cross and Blue Shield of Kansas members between the ages of 18 and 79 who are enrolled in an eligible health plan. This benefit is currently being offered to those with type 2 diabetes. There are some medical conditions that would exclude patients from the Virta treatment.

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Your health matters to us

Your health matters to us

HealthyOptions.

Enroll in a disease or wellness management program today

Personalized support

At Blue Cross and Blue Shield of Kansas, we have telephone-based disease and wellness management programs designed to help you improve your quality of life and overall health. When you enroll in one of the following programs, we will provide **one-on-one** support, coaching and education through regular telephone calls.

- Asthma¹
- High cholesterol
- COPD

- Maternity²
- Diabetes¹
- Stress management
- Heart disease
- Tobacco cessation²
- High blood pressure
- Weight loss

Our registered nurses can help you:

- Better understand your health risks and possible complications
- Make healthy lifestyle choices
- Improve communications with your healthcare team (doctors, nurses and others)
- Make informed health decisions

Health education

Knowledge is power! During routine calls, registered nurses will gather your health information and send you educational materials that will help you take an active role in your health and healthcare.

No additional cost

Our programs are provided at no additional cost to your existing health plan and will not affect your benefits. You can participate if you are an enrolled member and have Blue Cross and Blue Shield of Kansas as your primary health insurance carrier.



Enroll today!

Visit bcbsks.com/Enroll or call 800-520-3137

Participation in the program is completely voluntary. You may choose to discontinue participation in the program at any time. Participation in the program will not affect any health insurance benefits. State

of Kansas, Stormont Vail Health and Spirit AeroSystems employees should inquire about disease management program opportunities with their employer. For additional program details refer to the Member Rights & Responsibilities located at the bottom of bcbsks.com/DM.

Visit us at bcbsks.com













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Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross Blue Shield Association.

¹Ages 5+

² No age restrictions

Get care 24/7

Get care 24/7

Telehealth services allow you to get care whenever you need it.

Blue Cross members have access to virtual care services through their own network provider or Amwell. Amwell is convenient, affordable, private and secure.

Virtual care options

Telehealth through Amwell isn't meant to replace your primary care provider (PCP). Amwell is designed to provide care for non-emergency services when your PCP isn't available, after hours or on the weekend.

Ask your doctor about their virtual visit options. Virtual visits are covered the same as in-office visits under your Blue Cross plan.

Patient benefits:

- Available 24/7/365
- Less time away from work
- No travel expenses or time
- · Easier if you have a child or elder in your care
- Private and secure
- No exposure to other potentially contagious patients

When can I use it?

Consult a doctor and get prescriptions sent to the pharmacy of your choice for common conditions like:

- Cold or flu
- Sinus infection

Fever

Pink eye

Rash

Ear infection

Behavioral health services

Licensed therapists can provide advice and counseling for depression, anxiety, stress, relationship issues and more. Private and secure appointments are available through Amwell seven days a week, 6:00 a.m. to 10:00 p.m. CST.

Can my family use Amwell?

Yes, if your spouse and/or children are covered under your Blue Cross plan.



Register for Amwell – for free! bcbsks.com/telehealth

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Visit us at bcbsks.com



















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MC120 09/23

Welcome to BlueAccess

Welcome to BlueAccess[®]

Our secure online member portal is the gateway to your health information

With BlueAccess, you can quickly and securely:

- Check claims and view plan usage
- Find in-network doctors and hospitals
- Compare quality ratings for doctors
- Access your virtual ID card
- Contact customer support

Registration is quick and simple

- Go to bcbsks.com/blueaccess.
- Click Register for a BlueAccess account.
- 3 Have your ID card handy and follow the step-by-step instructions.

Once you have registered for a BlueAccess account, download the mobile app to track claims, find doctors and view your plan benefits from anywhere.



Scan to download the BlueAccess app or visit our website. **bcbsks.com/app**







For a complete look at your healthcare plan, log in to your BlueAccess account at bcbsks.com/blueaccess.

- 1 Manage My Account | Edit and manage your preferences and go paperless.
- **Forms** | Order a new ID card, find authorization forms and other forms related to your health insurance coverage.
- 3 Summary of Benefits and Coverage (SBC) and Contract/Certificate | View details about your coverage and contract.
 - View your copay, deductible and coinsurance amounts
 - Common medical coverage information
 - Coverage for specific tests or treatments
- 4 Explanation of Benefits (EOB) | See how much we paid, what your responsibility is and what the provider write-off amount is.
- Use this health and wellness platform to take a Health Assessment and generate a personalized health plan to reach your well-being goals.
- 6 Blue365° | Exclusive health and fitness deals and discounts.



1133 SW Topeka Blvd, Topeka, KS 66629 64

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How to have a Health Savings Account (HSA) with a Qualified High Deductible Health Plan

How an HSA Works



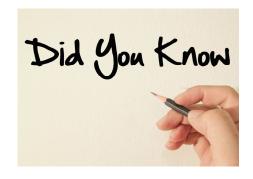




You control your HSA funds.

If you choose the HDHP, all eligible charges including office visits, lab, x-rays, diagnostic tests, office procedures, injections, outpatient surgery, inpatient hospital services and all other covered medical services are covered 100% for the balance of the year after satisfying the deductible. Preventive services are covered at 100% before meeting the deductible.

You do not pay federal, state or social security taxes on the money contributed to your HSA. As long as you spend the HSA money on eligible medical, dental or vision expenses, you will never pay taxes on the money contributed to the HSA.



IMPORTANT

You should open your HSA prior to the effective date of your High Deductible Health Plan (HDHP). Medical costs incurred after your HDHP is effective but before your HSA is established, can not be paid with money deposited in your HSA.

Health Savings Account Q & A

- 1. Who can have an HSA? The individual must be:
 - 1) covered by a qualified HDHP (Option #3 ONLY);
 - 2) not covered under other health insurance;
 - 3) not enrolled in Medicare, Medicaid or Tricare;
 - 4) not another person's dependent;
 - 5) not enrolled in a medical FSA plan;
- **2.** Where can I open an HSA? Many banks and credit unions offer HSA's.
- 3. When do I see the tax savings? When you do your taxes at the end of the year, it will be an above the line deduction, therefore your taxable income is reduced by the amount you contributed to your HSA.
- 4. If I switch jobs, do I lose my money? No. The money in your HSA is yours. Whatever money you contribute to your HSA is yours, just like if you had a bank savings account. If you do not use all your HSA money during the year, it will roll over to the next year.
- 5. How much can I contribute to my HSA account? In 2025, with single coverage, you can contribute up to \$4,300 per year and if two or more are insured, you can contribute up to \$8,550 per year. Age 55+ can contribute an additional \$1,000. Limits apply.
- 6. What are some examples of HSA qualifying expenses? HSA qualifying expenses include doctor office visits, prescription drugs, eye exams, glasses, contact lenses, chiropractors, laser eye surgery and birth-control prescriptions, to name a few. There are many more eligible items you can pay for with HSA money. You can get a list of covered expenses at www.irs.gov.
- 7. What happens if I lose my health insurance? You may continue to use your HSA money to pay for eligible expenses, even if you do not have a qualifying health insurance plan, but you cannot keep contributing money to your HSA.
- 8. Can I use my HSA money to pay for my premiums? HSA money can pay for health insurance premiums if you are collecting Federal or State unemployment benefits or are paying COBRA premiums.
- **9.** What if I need medical care in another country? You can use your HSA money for the same medical expenses anywhere in the world.
- **10. Can I withdraw my HSA money if I need to?** Yes, but the withdrawal is taxable and you will pay a 20% penalty for non-qualifying withdrawals.

- **11.** When I die, do I lose my HSA money? No. You can name a beneficiary to receive your HSA money.
- **12.** How much does it cost to set up an HSA? This depends on the bank or credit union you choose. Most usually have a one time set up fee, monthly fee, debit card fees, printed check fees, and overdraft fees. Shop around for the lowest fees.
- 13. Can my HSA be used for dependents not covered by the health insurance? Generally, yes. Qualified medical expenses include unreimbursed medical expenses of the account holder, his or her spouse, or dependents, even if they are not insured by a qualified HDHP.
- 14. Do I need to keep any records when I use my HSA?

 Although some financial institutions track the use of the HSA for you, it is a good idea to keep your own records. It is your responsibility to track the use of your HSA account and you may be required to show proof of your expenditures to the IRS. We recommend you designate a place to store all your receipts so they are available when you need them.
- 15. What if I do not use all of the money in my HSA account by the end of the year? All the money deposited in your HSA, but not spent during the year, rolls over to the next year. HSA's do not have a "use or lose it" provision. You have the option of accumulating money in your HSA to pay for future eligible expenses and never pay taxes on the money.
- **16.** Will my bank notify me if I have exceeded my allowable contribution amount? No, it is your sole responsibility to keep track of the amounts deposited and spent from your account.
- 17. I selected the HDHP (Option #3); is there anything else I need to do? Yes you will need to set up a health savings account (HSA) account with the bank of your choosing. If your bank doesn't offer an HSA account, it is available through First National Bank of Hutchinson, which has a branch in Goddard.

Once you have the account set up, bring your account information into our payroll/benefits department, and Cindy, Tamme or Michelle will get your direct deposit information updates for the pre-tax deduction to fund the HSA account.



Dental Plan

Administered by BCBS of KS

Our BCBS of KS plan is a PPO plan. When you receive services from a contracting dentist, you will receive the highest level of benefits allowed by the plan. You can search for contracting PPO and/or Premier dentists by visiting: www.bcbsks.com.

If you receive dental services from a non-contracting dentist, BCBS of KS will place a limit on the allowed amount. You will be responsible for all the expenses over the allowed amount. You will minimize your out-of-pocket expenses by using dentists who contract with the BCBS of KS.

Maximum	\$1,000.00 per person per Calendar Year
Preventive	 100% Oral examinations Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue and cavity detection Fluoride (under age of 21) Prophylaxis, including cleaning, scaling and polishing Space maintainers Sealants limited to one application per tooth per lifetime per eligible insured between 5 and 17 years of age inclusive, and limited to permanent molars and bicuspids (20 teeth).
Deductible	\$50 per person per plan year \$150 maximum per family per plan year Basic & Major Services are combined to meet the deductible
	80% after deductible
Basic	 Inlays Simple extractions Repair of dentures Fillings (except gold) Emergency treatment for pain Endodontics General anesthesia when the dental treatment is covered Periodontics, non-surgical Non-surgical care of acute oral infection and oral lesions Oral surgery, consisting of diagnosis and treatment of fractures, dislocations, cysts, and abscesses; and surgical extractions (including impacted teeth)
Major	 50% after deductible Periodontal surgery Surgery of the bony structure supporting the teeth Bridges Onlays (not part of a bridge) Crowns (not part of a bridge) Dentures, full or partial Dental implant services (\$1,000 lifetime max per insured, per arch)
Eligible Children Ages:	Children are eligible for coverage to age twenty-six (26)
Payroll Deductions	Monthly Rates
Employee	\$36.82
EE & Spouse	\$79.14
EE & Children	\$72.60
Family	\$114.50



Voluntary Vision Plan - Option 1

Services	In Network Member Cost	Out of Network Allowances	
VISION EXAM	\$10	\$35	
CONTACT LENS FIT & FOLLOW-UP	*Contact lens fit & 2 follow-up visits are available once a comprehensive eye exam has been completed		
Standard - spherical clear contact lenses in conventional wear & planned replacement (e.g. disposable, frequent replacement, etc.)	\$0	\$40	
Premium - all lens designs, materials & specialty fittings other than Standard Contact Lenses (e.g. toric, multifocal, etc.)	\$55 Allowance	\$40	
FRAMES any available frame at provider location	\$130 Allowance	\$65	
STANDARD PLASTIC LENSES			
Single Vision	\$25	\$25	
Bifocal	\$25	\$40	
Trifocal	\$25	\$55	
LENS OPTIONS			
Standard Polycarbonate	Adults \$40 Dependents under 19: \$0	\$25	
UV Coating	\$15		
Tint (Solid & Gradient)	\$15		
Standard Scratch-Resistance	\$15		
Standard Anti-Reflective Coating	\$45	Not Covered	
Standard Progressive (Add-On to Bifocal)	\$90		
Premium Progressive	\$90 + 80% of Retail, less \$120		
Other Add-Ons & Services	20% off Retail Price		
CONTACT LENSES (contact lens allowance includes materials only)	***Allowance not available if eyeglass lenses are elected***		
Conventional	\$130 Allowance, 15% off balance over \$130	\$100	
Disposable	\$130 Allowance \$100		
Medically Necessary	\$0	\$200	

Service frequencies are computed by date of service, not calendar year. Dependent children covered to age 26.

This summary assumes eligible vision services are provided by contracting providers.

 $If you \ receive \ vision \ services \ from \ a \ non-contracting \ provider, \ the \ benefits \ will \ be \ substantially \ less. \ See \ the \ plan \ document \ for \ more \ information.$

<u>Vision Plan - Option 1</u>	Monthly Premium
Employee Only	\$10.50
Employee & Spouse	\$22.08
Employee & Children	\$18.90
Family	\$35.40

Voluntary Vision Plan - Option 2

Materials Covered	In Network	Out of Network
FRAMES, LENS & OPTIONS PACKAGE: Any frame, lens, & lens options available at provider locations	\$200 Allowance for frame, lens & lens options, 20% off balance over \$200	\$100
CONTACT LENS (in lieu of frames, lens & options package)	\$200 Allowance	\$100

Service frequencies are determined by date of service, not calendar year. Dependent children covered to age 26.

This summary assumes eligible vision services are provided by contracting providers. If you receive vision services from a non-contracting provider, the benefits will be substantially less. See the plan document for more information.

If you receive vision services from a non-contracting provider, the benefits will be substantially less. See the plan document for more information.

Vision Plan - Option 2 Employee Only Employee & Spouse Employee & Children Family	Monthly Premium \$ 9.68 \$20.28 \$17.38 \$33.80
Family	\$33.80









316-462-3316

www.surency.com

To find a provider use the Access Network

Cafeteria Plan

The Flexible Spending Account Plan allows you to convert a portion of your taxable income into a non-taxable employee benefit. Since you pay for these items before taxes, your take-home pay increases because federal and state income tax, FICA and Medicare tax are not deducted from your paycheck. You must work a minimum of 30 hours per week to be eligible to enroll in the Health Care Spending Account.

A **Premiums Savings Plan** allows you to pay your share of eligible insurance premiums on a pre-tax basis from your payroll. Since these are pre-tax from your payroll they are not eligible to be reimbursed under the Flexible Spending Account.

A **Flexible Spending Account** (FSA) operates on a plan year basis. Each year you must elect to participate in the Flexible Spending Account. You estimate the amount of eligible expenses you and your dependents will likely incur, and from this amount, determine how much you would like to set aside in the Flexible Spending Account.

Maximum Allowed for Health Care Spending Account: \$3,300 per year/pre-tax

YOU MUST ENROLL EACH YEAR AT OPEN ENROLLMENT TO PARTICIPATE IN THE HEALTHCARE SPENDING ACCOUNT!

Health Care expenses not covered by your insurance company like deductibles and copays are eligible along with most dental and vision expenses. A list of some of the eligible expenses are shown on the following page.

CARRY OVER:

Up to \$660 of unused amounts in a current plan year's health flexible spending account (FSA) can be "carried over" to be paid or reimbursed to plan participants for qualified medical expenses incurred during the **2024** plan year. Any balance over \$660* will be forfeited. Carry-over funds will only be available to use during the runout period for expenses that occurred in **2024**.

RUN OUT PERIOD:

- ⇒ Run Out for <u>Active Employees</u> you have 75 days after the plan year ends to submit claims for dates of services incurred within the plan year.
- ⇒ Run Out for <u>Terminated Employees</u> you have 75 days after the date of termination to submit claims for dates of services incurred prior to the termination date.

Flex Accounts are spending accounts NOT savings accounts. Excluding the <u>carry over provision</u>, all money deposited into your Flex Spending Account must be spent each year as it will not carry over from one plan year to the next.

QUICK FACTS:

- Your plan year is January 1, 2025 through December 31, 2025.
- You can only use your FSA money to pay for expenses with a date of service within the plan year.
- You may not use money from your FSA to pay for expenses that have already been paid by another plan.
- You do not have to be enrolled in a medical plan with USD 265 to participate in the FSA!
- In most cases, you can use your FSA money to pay for expenses incurred by your spouse and dependents (up to age 26).
- The amount you contribute from your paycheck cannot be changed up or down during the year unless you have a qualified election change event.
- In the event your debit card is used to pay for ineligible expenses, a reimbursement will be necessary before your debit card will be available for further use.
- Your FSA benefit is directly tied to your active employment. Expenses after you leave employment are not eligible unless you continue the benefit via Cobra.

Need ideas on how to spend your flex dollars?

Go to www.fsastore.com for one of the largest selections of FSA eligible products online.



Cafeteria Plan

Most expenses applied to the deductible, coinsurance or copays of your health benefit plan are considered eligible expenses. For example, your health plan contains office visit, prescription drug and other copays. You may consider contributing money to your Flexible Spending Account so you can pay with tax-free dollars. Remember to keep your receipts in case it is needed to verify the medical expense. Use the lists below for reference, but keep in mind these lists do not include all eligible/ineligible expenses.

COMMON FSA ELIGIBLE EXPENSES					
Adult Diapers	Crutches	Hospital Services	Prescription Drugs		
Ambulance	Dental Treatment	Hot/Cold Therapy Packs	Prenatal Care (Vitamins)		
Athletic Care (ACE Bandages, etc.)	Denture Adhesives & Repair	Immunizations	Psychiatric/Psychologist Care		
Blood Pressure Monitors	Denture Pain Relief & Cleansers	Infertility Treatments	Smoking Deterrents (EX: Nicorette)		
Catheters	Diabetes Testing, Diabetes Supplies	Orthodontia	Splints & Casts		
Cholesterol Testing	Doctor's Office Visits	Orthopedic Supports	Thermometers		
Chiropractic Manipulations	Eyeglasses (Prescription & Reading)	Ovulation Kits	Transplants		
Contact Lenses, Solution, & Cleaners	Glucosamine and/or Chondroitin	Pap Smears	Vision Exams		
Contraceptives	Hearing Aids (& Batteries)	Physical Therapy	X-Ray Fees		

<u>INELIGIBLE</u> FSA EXPENSES					
Burial/Funeral Expenses	Fitness Programs/Health Club Dues	Marriage Counseling	Tanning		
Cosmetic Procedures	Funeral Expenses	Maternity Clothes	Teeth Whitening		
Dance Lessons	Household Help	Nutritional Supplements/ Vitamins (Over-the-Counter)	Toiletries (Toothbrush, Toothpaste, etc.)		
Diapers	Illegal Treatments	Piercings	Vacations		
Exercise Equipment (unless prescribed)	Insurance Premiums	Sunglasses (non-prescription)	Warranties (for Eyeglasses or Hearing Aids)		
Facelifts	Items Covered by Insurance	Swimming Lessons	Weight Loss Programs (unless prescribed)		

- Prescriptions are no longer required for OTC drugs to be considered an eligible expense. FSAs can now reimburse OTC drugs without a prescription. Participants will no longer need to provide prescriptions for OTC drug reimbursements effective immediately.
- $\sqrt{}$ Menstrual care products such as a tampon, pad, liner, cup, sponge, or similar products are now eligible expenses.

Questions Regarding your FSA Account?

Contact Flexible Benefit Service Corporation (FLEX)

Email: service@myflexaccount.com
Website: www.myflexaccount.com
Phone: (888) 345-7990

Available Monday through Friday 7am - 7pm Central Standard Time



Cafeteria Plan

FLEX DEBIT CARD:

The FLEX Card is a simple way to pay for qualified expenses without having to pay anything out-of-pocket. The flex card gives you access to the funds in your account by swiping the card at the point of sale and it can be used at any qualified service provider that accepts MasterCard. There are no out-of-pocket costs to you and no need to file a claim for reimbursement.



In some instances, Flex will notify you that they need additional documentation to confirm that your purchase was eligible. It's very important to **keep all of your receipts** and submit the information right away when necessary!

You will automatically receive a debit card for yourself when you enroll. To obtain a card for your spouse and/or children over 18, you will need to update their info on the Flex participant website. There is no cost for additional cards.

DEPENDENT CARE ACCOUNT:

Dependent Care Account <u>reimburses</u> you for eligible dependent care expenses with tax-free dollars. This account allows working parents to pay for qualified dependent care expenses like day care, nursery school, preschool, before/after-school care, and adult day care. You must work a minimum of 20 hours per week to be eligible to enroll in the Dependent Care Account.

Maximum Allowed for Dependent Care Account: \$5,000 per year pre-tax

YOU MUST ENROLL EACH YEAR AT OPEN ENROLLMENT TO PARTICIPATE IN THE DEPENDENT CARE ACCOUNT!

Eligible dependents must be under the age of 13, and/or physically or mentally unable to care for themselves and claimed as an exemption on your tax return. Dependents can include step-children, grandchildren, adopted children, or foster children.

The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, the service cannot be provided by your spouse, or by your dependents.

Only those dependent care expenses enabling you to work are eligible. Some expenses you incur during the plan year may not be eligible for reimbursement under current IRS regulations such as weekend or evening babysitting, transportation, food, clothing, entertainment, and registration fees.

***Please note the debit card is not available for dependent care expenses. It is a reimbursement account.

ELIGIBLE DEPENDENT CARE EXPENSES				
After/Before School Programs Latchkey (before & after school) Summer Day Camp Adult Day Care Center				
Child Care	Pre-School/Pre-K	Sick Child Care	Elder Care	
Day Care Center/Provider	Nanny	Disabled child daycare	Senior daycare	

<u>INELIGIBLE</u> DEPENDENT CARE EXPENSES				
Arts & Crafts Fees Field Trips Meals, Food, Snacks Overnight camp				
Boarding School	Household Services (maid, cook)	Nursing Home Care	Summer School	
Babysitting (not work related)	Kindergarten	School Tuition	Swimming Lessons	

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify.



FLEX - Website

Access your medical and/or dependent care accounts any time, 24/7. Simply create a user name and password to login and view your information, submit claims, check balances, etc. The participant website can be accessed at: www.myflexaccount.com

Registration

Step 1. If this is your first time accessing myflexaccount.com, simply click the register button atop the right corner of the home screen (as shown to the right). **USD 265 FLEX PLAN ID: FBS0054693**

Step 2. After clicking the register button, complete the registration form (as shown to the right). Create your own username and password. Enter the required demographic information. The standard employee ID provided by the administrator is your first initial + last name + last 4 digits of SSN (Example: John Smith = jsmith1234). If you do not know what your employee or employer ID is, please contact the customer service team at 1-888-345-7990. Before clicking Next, be sure to view and accept the terms of use.

After Step 2 continue to complete Steps 3 through 6 to finish setting up your account.





FLEX - Mobile App

The secure My Flex Account Mobile App helps you make smart money moves by providing convenient access to your FSA.

Easily:

- Check account balance
- Get transaction details and claim status
- Submit new claims and add itemized receipts to pending claims
- Update reimbursement method
- Manage your Flex Card (if applicable)

Download the free My Flex Account Mobile App today!





App icon to look for







Cafeteria Plan Worksheet

Estimate Your Expenses for the Upcoming Plan Year

(January 1, 2025 through December 31, 2025)

Estimate your out-of-pocket medical costs per year:		HERLTHCARE
Health insurance deductibles & coinsurance (not paid by insurance)	\$ 	7 8 9 X 9 4 5 6 1 Mg
Copays - office visits and prescription drugs (not paid by insurance)	\$ 	3/14
Wheelchair, crutches, medical appliances	\$ 	
Medical supplies	\$ 	
Mileage related to medical care	\$ 	
Other items	\$ 	
Total out-of-pocket medical expenses per year:	\$_	
Estimate your out-of-pocket dental costs per year:		
Examinations and cleanings, x-rays, etc.	\$ 	
Braces and retainers, fillings, etc.	\$ 	
Orthodontic, implants, inlays, other	\$ 	
Total out-of-pocket dental expenses per year:	\$_	
Estimate your out-of-pocket vision costs per year:		
Examinations, tests, etc.	\$ 	
Prescription eyeglasses, lens and frames	\$ 	
Contact Lenses and contact lens solution	\$ 	
Total out-of-pocket vision costs per year:	\$	
Fotal Health Care Expenses (maximum of \$3,300 per plan year)	\$ _	
Total Daycare Expenses (\$5,000 maximum per plan year)	\$ <u>_</u>	



Voluntary Life and AD&D Insurance

You may purchase Term Life and Accidental Death & Dismemberment insurance for yourself, spouse and/or children. The AD&D amount will be the same as the life amount elected.

You must elect coverage on yourself in order to elect coverage for your spouse and/or children. All benefits terminate upon retirement. If you terminate employment with USD 265 Goddard, you may be able to continue your coverage, but you need to notify Mutual of Omaha within 30 days of your termination to convert the group life coverage to your own individual policy.

Employee

- You may elect up to 5x your annual income from \$10,000 up to \$250,000 in increments of \$10,000;
- \$100,000 guarantee issue is only available during your first opportunity to elect coverage;
- Accidental Death & Dismemberment is equal to the amount of life insurance you select;
- Annual open enrollment employees can increase their existing coverage amount \$10,000 up to the guarantee issue amount (or 5x annual salary) without completing an Evidence of Insurability (EOI);
- Benefits reduce at age 70 to 50%;
- · Coverage terminates at retirement.

Spouse

- If employee elects coverage, spouse may elect from \$10,000 up to \$125,000 in increments of \$10,000;
- The minimum amount is \$10,000;
- \$30,000 guarantee issue is only available during the first opportunity to elect coverage;
- Coverage terminates at age 70.

Children

- If employee elects coverage, you may elect \$10,000 per child (coverage is guarantee issue);
- Dependent children include: 14 days old to age 19; to age 25 if full time student.

Features:

- Living Care/Accelerated Death Benefit (75% of the amount of the life insurance benefit if terminally ill, not to exceed \$250,000);
- · Waiver of Premium
- Additional AD&D Benefits (seat belt, airbag, common carrier)

RATES ARE SHOWN ON THE ON-LINE ENROLLMENT SYSTEM

When a Medical Questionnaire/EVIDENCE OF INSURABILITY (EOI) IS REQUIRED:

- Newly Eligible Employees or Spouses requesting coverage over the Guaranteed Issue Amount
- Employees that have previously waived coverage and enroll during open enrollment (any amount)
- Spouses that have previously waived coverage and enroll during open enrollment (any amount)
- Employee increasing coverage over \$10,000 or over the GI limit at open enrollment
- Spouse increasing coverage at open enrollment (any amount)



Voluntary Short Term Disability Plans

How long can you go without a paycheck?

If you are like most people, you do not have enough emergency savings to miss many paychecks. What are your chances of becoming disabled and unable to work? One in four 20 year olds today will become disabled before they retire.

You can ignore the problem, but it's hard to ignore the facts. Freak accidents are NOT usually the culprit. Back injuries, cancer, heart disease and other illnesses cause the majority of long-term absences.

Are you prepared if it happens to you? Probably not. If you're like most employees, you don't have the disability insurance or enough emergency savings to last 31.2 months. Yes, the average long-term disability claim lasts 31.2 months.

Mutual of Omaha is offering the following disability options to take away the worry of not being able to work and bring home a paycheck.

Short Term Disability Plans

Option 1

Waiting Period: Benefits payable on the 15th day

Benefit Amount: 66 2/3% of weekly salary

Benefit Maximum: \$1,000 per week

Benefit Duration: 24 weeks

Option 2

Waiting Period: Benefits payable on the 46th day

Benefit Amount: 66 2/3% of weekly salary

Benefit Maximum: \$1,000 per week

Benefit Duration: 20 weeks

Option 3

Waiting Period: Benefits payable on the 91st day

Benefit Amount: 66 2/3% of weekly salary

Benefit Maximum: \$1,000 per week

Benefit Duration: 13 weeks

Short-Term Disability benefits will not be paid while a member is receiving sick leave pay, personal leave pay, vacation leave, or other salary continuation, including donated amounts. Other sources of income, called "Deductible Income", may also reduce a benefit payment. Other sources of deductible income are defined in the insurance plan policy certificate. If this sum exceeds 100% of your Basic Weekly Earnings, the Weekly Benefit will be reduced by the amount over 100% of your Basic Weekly Earnings. The minimum weekly benefit payout is \$25.

RATES ARE SHOWN ON THE ON-LINE ENROLLMENT SYSTEM

During your annual open enrollment period, if you previously waived coverage you may enroll without submitting an Evidence of Insurability (EOI).



PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy.

Mutual of Omaha will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 6 months after You are continuously insured under the Policy.

Short-Term Disability Income Insurance



In accordance with federal regulations, maternity is treated like any other medical condition that prevents you from doing your job. After a normal delivery, benefits may be paid for up to six weeks. However, each situation is unique, so it is important to understand what your benefits are and how benefits are paid.

How do I file a claim?

There are three options available to file a claim:

Fax

- Go to mutualofomaha.com/support/forms and select the "Standalone Short-term Disability Claim Form."
- 2. Complete your section and have your employer and physician complete their sections, sign.
- 3. Fax ALL pages to Mutual of Omaha at 402-997-1865 or scan and email the complete form to newdisabilityclaim@mutualofomaha.com.

Online

- Go to mutualofomaha.com/support/forms and select the "Online Short-term Disability Claim Form — Employee Statement."
- Complete the online form by providing all requested information. We only accept Section 1 (Employee Statement) online.
- 3. Provide your physician's contact information (phone, fax, address) in the required field.

- 4. Print "Authorization to Disclose Personal and Health Information" form.
- 5. Complete, sign and fax to 402-997-1865 or scan and email the complete form to newdisabilityclaim@mutualofomaha.com.

Phone

- 1. Call 800-877-5176 and a customer service representative will complete Section 1 (Employee Statement) with you.
- 2. Following the call, print the "Authorization to Disclose Personal and Health Information" form.
- 3. Complete, sign and fax to 402-997-1865 or scan and email the complete form to newdisabilityclaim@mutualofomaha.com or mail to:

Mutual of Omaha Insurance Company Attn: Group Insurance Claims 3300 Mutual of Omaha Plaza, Omaha, NE 68175-0001.



Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Disability income is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ 2010 or state equivalent (7000GM-U-EZ 2010 NC). Some exclusions and limitations may apply

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Short-Term Disability Income Insurance

When do my benefits begin?

Your disability usually begins on the date of your delivery. However, there may be a short period of time, called an **elimination period**, before benefit payments actually begin. Ask your employer or review your certificate booklet to determine the length of your elimination period.

When do my benefits end?

The approval period typically ends six weeks after your delivery date. If you experience a medical complication that prevents you from performing your job, we will review the medical records provided by your physician and may extend your benefits beyond this time frame.

Will I receive benefits if I stop working before my due date?

If you experience medical complications that prevent you from performing your job, we will review medical records provided by your physician and may provide benefits prior to your expected delivery date.

Will I continue to receive benefits, if my physician says I should stay home beyond the six weeks?

Benefits will only extend beyond six weeks if there are medical complications. Your physician will be required to provide certification that the disability will last more than the initial six weeks. Mutual of Omaha will review your medical records and the physical requirements of your job and determine if we will extend your benefits.

For a Cesarean section, if your physician provides certification, we will extend benefits up to an additional two weeks, for a total of up to eight weeks from your delivery due date.

What if I am able to return to work before six weeks?

Your benefits may be adjusted due to an earlier return to work date. Contact Mutual of Omaha at 1-800-877-5176.

I was told I was eligible for six week of benefits, but why did I only receive five weeks of benefits?

You may not receive benefits for all six weeks of your leave.

Actual benefits may vary, depending on the date you deliver and your **elimination period**.

For example, if you deliver on Jan. 15 and have a seven-day elimination period (the period of time after you deliver, but before benefits start), your benefits would begin on Jan. 22 and would end six weeks after the date you delivered, on Feb. 25. In this scenario, you would receive only five weeks of disability benefits.

Isn't everyone eligible for 12 weeks of leave?

Under the federal Family and Medical Leave Act (FMLA), certain employees can take up to 12 weeks of leave for certain family or medical emergencies. The law also provides that, in most cases, you will have a job with your employer when you return from leave. FMLA does not, however, require your employer to provide you with insurance coverage or a paycheck during the leave. Although it is possible to receive disability benefits while on an FMLA leave, FMLA is separate from the disability coverage provided by Mutual of Omaha. Please contact your employer's Human Resources Representative for more information about FMLA.

Will benefits be extended if I need time to bond with my baby?

Benefits for covered individuals are paid only to employees with disabling medical conditions that prevent them from performing their job.

Can my spouse qualify for paternity benefits?

No. Benefits are available when a covered individual is unable to perform their job due to their own sickness or injury.

I am or may be eligible to receive benefits through a state disability plan. How will this impact my benefits with Mutual of Omaha?

Other benefits that you receive or are eligible to receive due to your disability may reduce the benefit payable by Mutual of Omaha. If you are eligible to receive benefits through a state disability plan, you will need to complete the appropriate filing process to receive these benefits. Please refer to your short-term disability policy to determine if these benefits are an offset.

Voluntary Critical Illness Plan

A group critical illness plan helps prepare you for the added costs of battling a specific critical illnesses. The good news is many people with a critical illness survive these life-threatening battles.

As the recovery process begins, most people worry about the bills that have piled up. Our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness.

Benefit Separation Period - 6 months

If an insured person who was diagnosed with a critical illness in one benefit category is subsequently diagnosed with a critical illness in a different benefit category, the dates of diagnosis must be separated by 6 months or more for subsequent benefits to be payable. There is no benefit separation period between critical illnesses diagnosed within the same benefit category.

Additional Category Occurrence Benefit - Included

This benefit allows an insured person to receive up to 200% of the CI Principal Sum in the Heart/Circulatory and Organ Categories, subject to any policy benefit maximum. An additional benefit is only payable if the date of diagnosis for an additional critical illness occurs at least 12 months after the date of diagnosis of a previous critical illness for the insured person in the same Benefit Category for which benefits were paid.

Re-occurrence Benefit - 50%

If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, the full benefit will be payable again if the two dates of diagnosis are separated by at least 12 months and the insured has been treatment free.

Benefit Waiting Period - 30 Days

An insured person must be insured for a minimum of 30 days before becoming eligible for CI benefits. If an insured person is diagnosed with a critical illness during this period, benefits are not payable.

Pre-Existing Condition Limitation - 12/12

Benefits are not payable for any critical illness caused by, attributable to or resulting from a pre-existing condition until 12 months after an insured person is continuously insured. A pre-existing condition includes any critical illness for which an insured person received treatment in the 12 months prior to the date the person became insured.

\$50 - Health Screening Benefit

Payable once per calendar year for each insured person who has a health screening test performed.

ANNUAL WELLNESS BENEFIT - \$50.00 For Each Insured per Calendar Year



The following is a list of covered illnesses and the percentage of benefits payable for each illness:

Percent	
Covered	Covered Illness
100%	Heart Attack
100%	Heart Transplant
100%	Stroke
100%	Major Organ Transplant
100%	End-Stage Renal Failure
100%	Cancer (Invasive)
50%	Bone Marrow Transplant
25%	Heart Valve Surgery
25%	Coronary Artery Bypass
25%	Aortic Surgery
25%	Acute Respiratory Distress Syndrome
25%	Carcinoma in Situ
25%	Benign Brain Tumor
	Available for Children Only
100%	Cerebral Palsy*
100%	Structural Congenital Defects*
100%	Genetic Disorders*
100%	Congenital Metabolic Disorders*
100%	Type 1 Diabetes*
	* Only payable once per insured person under the policy

	Monthly Rates				
	Employee		Spo	Spouse	
	\$10,000 Benefit		\$5,000	Benefit	
	Non-		Non-		
Age Bands	Tobacco	Tobacco	Tobacco	Tobacco	
Ages 0-24	\$3.90	\$4.40	\$1.95	\$2.30	
Ages 25-29	\$4.90	\$5.50	\$2.25	\$2.80	
Ages 30-34	\$6.40	\$7.40	\$3.00	\$3.95	
Ages 35-39	\$8.50	\$10.40	\$4.15	\$6.00	
Ages 40-44	\$12.20	\$15.90	\$6.35	\$10.00	
Ages 45-49	\$16.70	\$24.00	\$9.65	\$16.80	
Ages 50-54	\$21.80	\$35.40	\$14.20	\$26.25	
Ages 55-59	\$28.30	\$51.00	\$19.85	\$39.20	
Ages 60-64	\$39.30	\$77.30	\$28.45	\$59.70	
Ages 65-69	\$53.00	\$111.90	\$38.65	\$85.65	

Employee and spouse premiums are calculated with the employee/member's age as of the effective date of the plan.
Rates are adjusted once each year on the plan anniversary date that coincides with or follows the day an employee/member reaches the starting age of the next age band.

Child coverage is automatic at 25% of employee amount up to \$5,000. A separate premium is not required.
Children are covered up to age 26.

Tobacco rates apply for any use of tobacco or nicotine replacement within the past 12 months.

The only opportunity to enroll in Critical Illness is as a new hire or your annual Open Enrollment. If you have previously waived coverage and want to enroll at Open Enrollment, you will need to complete an Evidence of Insurability (EOI).

Qualifying events and status changes during the plan year do <u>not</u> allow enrollment.

Voluntary Accident Plan

Mutual of Omaha's Group Accident Plan provides benefits to help cover the costs associated with unexpected medical bills. When a covered accident occurs, the last thing you want to worry about is how to pay the bills. Mutual of Omaha's Group Accident Plan pays YOU the benefit regardless of any other insurance.

Features:

- 24 hour coverage on and off the job
- Pays regardless of any other insurance
- Benefits for in-patient and out-patient treatment
- Guaranteed issue for new employees
- Portable coverage

Accident Benefits

- 100 Emergency Room
- \$ 75 - Urgent Care Center
- \$ \$ \$ \$ \$ 50 - Initial Physician Office Visit
- 50 Follow Up Treatment (up to 2 per accident)
- 100 Diagnostic Exam
- 100 Ground Ambulance (\$500 Air Ambulance)
- 750 Hospital Admission
- 100 Hospital Confinement per Day
- 300 Hospital Intensive Care per Day
- 50 Rehabilitation Facility Confinement (up to 30 days per accident)

Fractures

- \$ 1,500 3,000 / Hip
- \$ 750 - 1,500 / Vertebral Body
- \$ 750 - 1,500 / Thigh or Lower Leg
- \$ 300 - 600 / Forearm, Hand, Foot, Ankle or Knee Cap
- 300 600 / Shoulder Blade or Lower Jaw
- 50 100 Finger or Toe

Lacerations

- \$ 25 - Not requiring stitches
- \$ 50 - Less than 2 inches
- 150 2 inches to 6 inches long
- \$ 400 - More than 6 inches long

Burns

- 50 \$500 Second Degree Burns
- \$1,000 \$5,000 Third Degree Burns

Accidental Death

- \$ 25,000 Employee (\$50,000 Common Carrier)
- \$ 12,000 Spouse (\$24,000 Common Carrier)
- \$ 2,000 Children (\$ 4,000 Common Carrier)

Dismemberment Benefit

- 100% Loss of both hands, feet, sight of both eyes
- 100% Loss of Speech and Hearing (in both ears)
- 50% Paralysis of both upper and lower limbs
- 50% Loss of one hand, one foot, sight of one eye or loss of hearing (both ears)
- 25% Paralysis of one limb



Monthly	
Premium	Who's Covered
\$8.50	Employee Only
\$12.55	Employee and Spouse
\$14.50	Employee and Children
\$19.01	Family





The only opportunity to enroll in the Accident Plan is as a new hire or your annual Open Enrollment.

Qualifying events and status changes during the plan year do not allow enrollment.



Employee Assistance Program

Employee Assistance Summary of Services



What is an EAP?

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with free, confidential, in-the-moment support to help with personal or professional problems that may interfere with work or family responsibilities.

What Happens When You Call the EAP?

A Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.*

Common Reasons to Call Your EAP

Common	toubolls to co	di loai mil	
Relationships	Life Events	Risks	Challenges
Boss/	Birth/Death	Burnout/Anger	Daily
Co-worker	Health/	Depression/	responsibilities
Customers	Illness	Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal thoughts	Parenting
Spouse/Kids	Promotion/ Retirement	Substance abuse	Stress/ Conflict

PROGRAM FEATURES:



Program Cost

This benefit is provided at NO COST* to you and is paid for by your employer.



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.

Information about your problem cannot be released without your written permission.



Available 24/7

Services are available 24-hours a day, 7-days a week via a toll-free number.

Help is just a phone call away.

Call or text to access services.

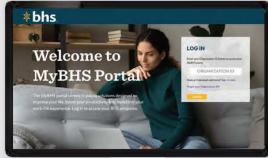
800-327-2251

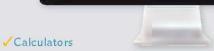
MyBHS Portal

The mobile-friendly MyBHS customer portal provides access to more than 500,000 tools and resources on a variety of well-being and skill-building topics.

Features:

- ✓ Program Information
- ✓ Access to Services
- ✓ Announcements
- ✓ Assessments
- √Café Series Webinars
- ✓ Training Center





Access the MyBHS Portal online or via the app. portal.BHSonline.com
ID: GODDARDUSD





✓ Legal Forms

√ News & Tips

✓ And more...

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^{*} If you require a referral for long-term treatment, costs may be incurred. These are often covered by your health insurance plan.

Employee Assistance Program

How to Access Services





Call 800-327-2251

Free, confidential, in-the-moment support is available 24/7 to help with personal or work-related problems that may interfere with your job or family responsibilities. A BHS Care Coordinator will confidentially answer your call, understand your need, assist with any emergencies and connect you to the appropriate resources. They will then follow up with you to ensure your satisfaction and progress.





Text 800-327-2251

Text BHS to ask a question about the program, get in-the-moment support (routine needs only) or initiate services. All texts will be answered within one (1) business day.*

To start a conversation, simply send a text and use one of the following hashtags:

#BEBETTER to connect with a master's level Care Coordinator #WORKLIFE to connect with a Work-Life Resource Specialist





portal.BHSonline.com

The MyBHS Portal provides access to services, contains information about your program and offers unlimited access to thousands of tools, resources and trainings on a variety of well-being and skill-building topics.

Connect with a BHS Care Coordinator

Live Chat connects you with an available BHS representative to answer questions, provide in-the-moment support or to initiate services.

Or, fill out the Service Request Form** and a BHS representative will respond within one (1) business day.





The BHS App

One-touch Dialing - Call our toll-free number 24/7 to speak with a BHS Care Coordinator for urgent needs.

Ask a Question - Submit a question or request services and a BHS representative will respond within one (1) business day.

Access the MyBHS Portal - Contains information about your program and unlimited access to thousands of tools, resources and trainings on a variety of well-being and skill-building topics.





^{*}Text messages are answered during regular business hours, Monday-Friday 8 a.m.-8 p.m. ET, excluding holidays. Text users must be 18 or older. Not available for California residents. Text services are not intended for emergencies or urgent issues – please call 9-1-1 or 800-327-2251 for immediate help.

^{**}Individuals under the age of 18 are invited to call our toll-free service line to request services in lieu of online requests due to age of consent laws that vary by state.



403(b) Retirement Plan

Goddard Public Schools offers a 403(b) Tax sheltered Account Plan. As an eligible employee you have the ability to participate in this Plan by making voluntary salary reduction contributions to the Plan. Employee must be assigned and working 20 or more hours per week to be eligible.

What kinds of contributions may be made to this plan?

This plan provides for pre-tax salary reduction contributions, post-tax Roth salary reduction contributions and rollovers. Pre-tax contributions are deducted <u>before</u> you pay current income taxes. Pre-tax investments grow tax-deferred and the contributions and any earnings are taxed when you take a distribution from this plan. Post-tax Roth contributions are deducted <u>after</u> you pay current income taxes. Earnings on post-tax Roth contributions will never be taxed if you are 59 ½, die or become disabled and have held the Roth account for 5 years at the time of its distribution from this plan. You may roll over benefits from a former employer's eligible retirement plan into this plan. Employer contributions may be made to the plan. Please consult your employer or financial representative for the types of employer contributions the plan allows.

How much may I contribute?

You can contribute up to 100% of your compensation to this plan up to the limit allowed under the Internal Revenue Code (\$23,500 in 2025).

If you are age 50 or older, you can contribute a "catch-up" contribution of up to \$7,500.

Can I ever lose my benefits?

You are always 100% vested in your salary reduction contributions. This means the value of your contributions and earnings are yours when you terminate employment with your employer, without respect to your years of service.

What do I have to do to start contributing?

Automatic payroll deduction withdraws your contributions directly from your paycheck after you complete a Salary Reduction Agreement and return it to your financial representative or your employer. You may commence making contributions or modify the amount of your current contributions at any time by modifying your Salary Reduction Agreement.

You may obtain a list of financial representatives that can assist you by visiting: http://www.bbadmin.com

Once you have accessed the website please follow these instructions:

- Select Employee from the left menu
- Select your state from the drop down menu
- Select your employer from the second drop down menu
- Select the "Approved Providers/Products/Reps" link

Participating 403(b) Investment Providers

The following investment providers are available for remittance of salary reduction contributions and transfers under the 403(b) Plan:

Provider	Contact	Phone Number	Address	Email
AMERICAN FIDELITY ASSURANCE CO.	AMERICAN FIDELITY ASSURANCE	(800) 662-1106	P.O. BOX 25520 OKLAHOMA CITY, OK 73125	
AMERIPRISE FINANCIAL SERVICES	KIMBERLY READ	(620) 663-9505	13 W 11TH AVE HUTCHINSON, KS 67501	
AMERIPRISE FINANCIAL	MARK NANCE	(620) 276-8025	2606 FLEMING ST GARDEN CITY, KS 67846	LARRY.M.NANCE@AMPF.COM
EQUITABLE	CONNOR HAMPTON	(316 641-8079	7309 E 21ST ST STE 120 WICHITA, KS 67217	CONNOR.HAMPTON@EQUITABLE .COM
FIDUCIARY TRUST CO. OF NEW HAMPSHIRE	AMY MCKINLEY	(316) 721-6767	8925 W. MAPLE ST STE 15 WICHITA, KS 67209	
FIDUCIARY TRUST CO. OF NEW HAMPSHIRE	BRENT DOME	(316) 201-6655	8925 W. MAPLE ST STE 1 WICHITA, KS 67209	
PLANMEMBER REP	PARKER MALDONADO	(316) 260-9203	9324 W. CENTRAL WICHITA, KS 67212	PARKER.MALDONADO@KSEDUPL US.COM
HORACE MANN LIFE INS. CO.	ROD W MYERS	(316) 788-2894	P.O BOX 247 DERBY, KS 67037	ROD.MYERS@HORACEMANN.CO M
PCS RETIREMENT -ASPIRE FINANCIAL SERVICES	ASPIRE FINANCIAL SERVICES	(866) 634-5873	4010 BOY SCOUT BLVD STE.500 TAMPA, FL 33607	
PLANMEMBER FINANCIAL CORP.	PLAN MEMBER SERVICES	(800) 874-6910	6187 CARPINTERIA AVE. CARPINTERIA, CA 93013	
OFG FINANCIAL SERVICES	IAN LINDSTROM	(316) 990-8923	7309 E 21st ST N STE 130 WICHITA, KS 67206	IANLINDSTROM@OFGFINANCIAL. COM
OFG FINANCIAL SERVICES	MICHAEL PECK	(316) 249-6762	13461 W LINKS ST. WICHITA, KS 67235	MIKEPECK@OFGFINANCIAL.COM

UPDATED 11/1/24

State of Kansas Public Employees 457(b) Deferred Compensation Plan (KPERS 457)



Features and highlights

About KPERS 457

KPERS 457 is a governmental 457(b) deferred compensation plan. It's a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving pretax dollars through a voluntary salary contribution.

Traditional pretax or Roth after-tax contributions

You can choose to pay taxes on your contributions now, when you take money out or both. Consider the amount of taxes you might be paying in retirement.

State employees

You have the flexibility to designate all or part of your deferrals as Roth after-tax contributions.

Local employees

Check with your employer to see if the Roth option is available.

Eligibility requirements

All employees of any participating KPERS 457 employer are eligible to contribute to the 457 plan, including full-time, part-time and seasonal employees (excluding contractors).

Enrollment

You can enroll at **kpers457.org** or by phone at **800-232-0024.** You will need a Group Number and Plan Enrollment Code, which are available from your employer.

Contributions

The minimum amount you can contribute to each plan is \$12 or 1% per pay period. The IRS sets annual contribution limits for 457(b) plans. You can contribute:

- Up to 99% of your salary or \$23,000 in 2024, whichever is
- An additional \$7,500 as a catch-up contribution if you are age 50 or older.

KPERS 457 also offers a special catch-up provision. If you are within three calendar years of your normal retirement age, you can contribute up to twice the regular limit — \$46,000. The amount you are able to contribute for the special catch-up is based on amounts you were eligible to contribute in previous years but did not. You can't use both catch-up contribution types in the same calendar year.

Contribution and investment changes

Log on to the website or call the Customer Care Center to change your contributions. You can also change your investment options at any time.¹

Rollovers

KPERS 457 allows you to roll over balances from eligible 457(b), 401(k) or 403(b) plans or from an Individual Retirement Account (IRA). Consider all your options and their features and fees before moving money between accounts.²

Investment options

A self-directed brokerage account (SDBA) and a wide array of core investment options are available in the plan. You can find investment option information at **kpers457.org** or by calling **800-232-0024**.

The SDBA is intended for knowledgeable investors who understand the risks associated with the SDBA.

Want help?

We know investment decisions can be confusing, so KPERS 457 has two services that you can use:

Online Advice

Online Advice, provided by Empower Advisory Group, LLC, a registered investment adviser, is designed to help you choose specific investments based on your personal goals and financial situation. This service is only available through the website.

Point-in-Time Advice

A powerful phone-based service that can help answer questions about:

- Whether you should consolidate some of your accounts
- How to invest your contributions in KPERS 457
- How much you should save in KPERS 457
- Taking distributions from KPERS 457 once you've left employment

These services are available at no additional cost to you. There is no guarantee provided by any party that participation in any of the advisory services will result in a profit.

800-232-0024 kpers457.org

KPERS 457



Withdrawals

Qualifying distribution events:

- Retirement
- Severance of employment (as defined by Internal Revenue Code provisions)
- Reaching age 73 (The IRS generally requires you to start taking required minimum distributions (RMDs) at age 73. If you turned 72 in 2022 and delayed your first-time RMD until April 1, 2023, you must take your 2022 RMD by April 1, 2023, and your 2023 RMD by December 31, 2023.)
- Death (your beneficiary receives your benefits)
- Unforeseeable emergency (as defined by the Internal Revenue Code)
- · Birth or adoption of a child
- · Transfer to purchase pension service credit

Pretax distributions are subject to income tax except for a transfer to purchase pension service credit. To receive a tax-free distribution of Roth contributions, you must have had the account for at least five years and meet certain requirements.

The 10% early withdrawal penalty that applies to 401(k) plans and IRAs generally does not apply to distributions from your KPERS 457 account.² Keep in mind that once your employment has ended, you have many choices, including leaving your money in KPERS 457.

Plan costs

Costs for participating in KPERS 457 include:

- An annual charge of 0.10% deducted monthly for an Empower administrative cost
- An annual charge of 0.048% deducted monthly for a KPERS administrative cost
- An investment management cost that varies by investment option
- Transactional costs for participation in the SDBA option Loans

If your employer offers loans, you can borrow up to \$50,000 or 50%

- A loan must be repaid within five years (20 years if used to purchase your primary residence).
- There is a \$100 origination fee for each loan.

of your vested account balance, whichever is less.

· You may have one loan at a time.

Helpful resources

More information is available at **kpers457.org** or at **800-232-0024.** If you're looking for general information related to your retirement savings or want to go over the benefits of your plan, you can also meet with a Retirement Plan Counselor throughout the state of Kansas. If you have any questions about your KPERS 457, visit **kpers457.org** to schedule a meeting.

Investing involves risk, including possible loss of principal.

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¹ Transaction requests received in good order after the close of the New York Stock Exchange will be processed the next business day.

² Funds rolled into a governmental 457 plan from another type of plan or account may still be subject to the 10% early withdrawal penalty if taken before age 591/2.

³ Withdrawals may be subject to ordinary income tax. The 10% federal early withdrawal penalty does not apply to deferred compensation plan withdrawals except for withdrawals attributable to rollovers from another type of plan or account.

KPERS 457

HELP YOUR EMPLOYEES SOAR

kpers457 alongside KPERS for better financial security

KPERS and KPERS 457 are better together

KPERS 457 is the State's deferred compensation plan. It's an additional savings option designed to help your employees supplement their KPERS or KP&F pension for a more sound retirement.



Many financial professionals suggest replacing at least 80% of one's income for retirement. KPERS and Social Security probably won't be enough, especially for KPERS 3 members. KPERS 457 provides an easy way for employees to save.

And it's offered at no cost to employers.





- No minimum number of employees
- Roth or pretax option
- Ontributions automatically deducted from employee's pay
- Employees can contribute as little as \$12 per pay period
- ▶ Employers are not required to match contributions
- You can offer KPERS 457 if you already have a 457(b) or 403(b) plan
- Most Kansas public employers even those without KPERS can offer KPERS 457
- Easy to adopt
- ▶ KPERS handles fiduciary duties, reducing your workload and liability
- Counselors are salaried
- A State-provided benefit available to you, as an employer, to add KPERS 457 for your employees



1-816-783-7049 | kpers457.org

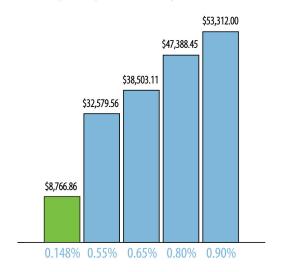
KPERS 457



KPERS and KPERS 457 = big picture

KPERS and KPERS 457 are separate benefits, but the two plans work together to help employees see the big picture when it comes to their retirement. When a KPERS 457 participant logs in to their account, they can see their pension info (if they are a vested member) along with a Social Security estimate (if they contribute).

Costs to participants over 30 years



Administrative expenses

FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not represent the performance of any investment options and does not include all plan expenses. It assumes a beginning balance of \$20,000, contributions of \$100 every two weeks and a hypothetical 6% annual rate of return with reinvestment of all earnings and no withdrawals.

The chart above compares the KPERS 457 annual cost of 0.148% with other plans' potential costs up to 0.90%. It may not sound like much, but over the course of a long career, higher costs can result in thousands of dollars of expenses. Paying less may allow your employees to save more for retirement.

How much will it cost employees?

Sometimes it can be hard to see costs associated with retirement plans. There are usually administrative and investment costs. KPERS 457 makes them clear, fair and as low as possible.

0.148%
Vary by investment

Service provider and fiduciary oversight Investment expenses charged directly by investment managers; vary by employee investment selection

The annual service/oversight rate is divided by 12 and deducted monthly based on a participant's account balance. That means for every \$1,000 invested, the administrative cost is \$1.48 a year.



Get started with KPERS 457 today!

Give us a call at **1-816-783-7049** if you have questions or need additional information.

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Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:



Explanation of benefits

Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?



Prescription challenges

Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?



Benefits questions

Are you unsure if the insurance company will pay for a certain procedure?



Claim issues

Did you receive a bill from a doctor but don't know why?



Difficult situations

Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

ajg.com

The Gallagher Way. Since 1927.

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Email:

bac.usd265goddardadvocates@ajg.c

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Hours of operation

Monday - Friday 7 a.m. - 8 p.m. Central Time

FMLA

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For the birth and care of the newborn child of an employee;
- For placement with the employee of a child for adoption or foster care;
- To care for employee's spouse, child, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may be also taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees are required to use accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

FMLA (cont)

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military Employees also must inform the family leave. employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for the involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.



Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

USD 265 Goddard Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the USD 265 Goddard Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program — If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Nick Grummert - Director of Human Resources at (316) 794-4000 or ngrummert@goddardusd.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Women's Health & Cancer Rights Act

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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: \$1,500 PPO Plan (Individual: 50% coinsurance and \$1,500 deductible; Family: 50% coinsurance and \$3,000 deductible)

Plan 2: \$3,500 PPO Plan (Individual: 50% coinsurance and \$3,500 deductible; Family: 50% coinsurance and \$7,000 deductible)

Plan 3: \$5,000 HDHP PPO Plan (Individual: 0% coinsurance and \$5,000 deductible; Family: 0% coinsurance and \$10,000 deductible)

If you would like more information on WHCRA benefits, please contact Nick Grummert - Director of Human Resources at (316) 794-4000 or ngrummert@goddardusd.com.

Summary of COBRA Benefits

A temporary extension of health benefits may be available in certain instances where coverage under the plan would otherwise end. Please refer to the COBRA Notice previously provided to review your rights and obligations under the continuation of coverage provisions of the law.

This chart shows the maximum period for which continuation coverage must be offered for the specific qualifying events and the qualified beneficiaries who are entitled to elect continuation coverage when the specific event occurs. **Note that an event is a qualifying event only if it causes the qualified beneficiary to lose coverage under the plan.**

Your coverage will be billed directly from the insurance company at the group rate plus a 2% administrative fee. The health, dental and vision may be continued under COBRA.

Qualifying Event	Qualified Beneficiary	Number of Months
Employee terminates employment or hours reduced.	Employee, Spouse, Dependent Child	18
Employee loses coverage because the employer files for Chapter 11 bankruptcy.	Employee and all covered dependents.	18
The employee becomes disabled.	Employee and all covered dependents.	29
The employee becomes eligible for Medicare due to age while on COBRA.	All covered dependents.	36
The employee's death.	All covered dependents.	36
Divorce or legal separation.	All covered dependents.	36
Dependent child no longer qualifies as a dependent (e.g., reaches the maximum dependent age).	Dependent child upon reaching the maximum dependent age.	36

Notice of Creditable Coverage

Important Notice from USD 265 Goddard

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 265 Goddard 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:

- 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 265 Goddard has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current USD 265 Goddard coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current USD 265 Goddard coverage, be aware that you and your dependents will 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 265 Goddard 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 265 Goddard 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: January 01, 2025

Name of Entity/Sender: USD 265 Goddard

Contact—Position/Office: Nick Grummert- Director of Human Resources

Office Address: 201 S Main, PO BOX 249

Goddard, Kansas 67052-0249

United States

Phone Number: (316) 794-4000

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/	The AK Health Insurance Premium Payment Program
Phone: 1-855-692-5447	Website: http://myakhipp.com/
11011011 2 000 001 0 117	Phone: 1-866-251-4861
	Email: CustomerService@MyAKHIPP.com
	Medicaid Eligibility:
	https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/	Health Insurance Premium Payment (HIPP) Program Website:
Phone: 1-855-MyARHIPP (855-692-7447)	http://dhcs.ca.gov/hipp
	Phone: 916-445-8322
	Fax: 916-440-5676
	Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) &	
Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website:	Website: https://www.flmedicaidtplrecovery.com/
https://www.healthfirstcolorado.com/	flmedicaidtplrecovery.com/hipp/index.html
Health First Colorado Member Contact Center:	Phone: 1-877-357-3268
1-800-221-3943/State Relay 711	
CHP+: https://hcpf.colorado.gov/child-health-plan-plus	
CHP+ Customer Service: 1-800-359-1991/State Relay 711	
Health Insurance Buy-In Program (HIBI):	
https://www.mycohibi.com/	
HIBI Customer Service: 1-855-692-6442	
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-	Health Insurance Premium Payment Program
premium-payment-program-hipp	All other Medicaid
Phone: 678-564-1162, Press 1	Website: https://www.in.gov/medicaid/
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party	http://www.in.gov/fssa/dfr/
-liability/childrens-health-insurance-program-reauthorization-act-2009-	Family and Social Services Administration
chipra	Phone: 1-800-403-0864
Phone: 678-564-1162, Press 2	Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website:	Website: https://www.kancare.ks.gov/
lowa Medicaid Health & Human Services	Phone: 1-800-792-4884
Medicaid Phone: 1-800-338-8366	HIPP Phone: 1-800-967-4660
Hawki Website:	Tim T Hone: 1 000 307 1000
Hawki - Healthy and Well Kids in Iowa Health & Human Services	
Hawki Phone: 1-800-257-8563	
HIPP Website: <u>Health Insurance Premium Payment (HIPP) Health &</u>	
Human Services (iowa.gov)	
HIPP Phone: 1-888-346-9562	
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
HIPP) Website:	Phone: 1-888-342-6207 (Medicaid hotline) or
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	1-855-618-5488 (LaHIPP)
Phone: 1-855-459-6328	
Email: KIHIPP.PROGRAM@ky.gov	
KCHIP Website: https://kynect.ky.gov	
Phone: 1-877-524-4718	
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?	Website: https://www.mass.gov/masshealth/pa
language=en_US	Phone: 1-800-862-4840
Phone: 1-800-442-6003	TTY: 711
TTY: Maine relay 711	Email: masspremassistance@accenture.com
Private Health Insurance Premium Webpage:	
https://www.maine.gov/dhhs/ofi/applications-forms	
Phone: 1-800-977-6740	
TTY: Maine relay 711	MICCOLIDI. Mardinald
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-800-657-3672	Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	
	Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-800-694-3084	Phone: 1-855-632-7633
Phone: 1-800-694-3084 Email: <u>HHSHIPPProgram@mt.gov</u>	Phone: 1-855-632-7633 Lincoln: 402-473-7000
Email: HHSHIPPProgram@mt.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Email: <u>HHSHIPPProgram@mt.gov</u> NEVADA – Medicaid	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid
Email: http://dhcfp.nv.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health
Email: <u>HHSHIPPProgram@mt.gov</u> NEVADA – Medicaid	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Email: http://dhcfp.nv.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218
Email: http://dhcfp.nv.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218
Email: http://dhcfp.nv.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218
Email: http://dhcfp.nv.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218
Email: HHSHIPPProgram@mt.gov NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 NEW HAMPSHIRE – Medicaid 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/
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OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org	Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-888-365-3742	Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-	Website: http://www.eohhs.ri.gov/
health-insurance-premium-payment-program-hipp.html	Phone: 1-855-697-4347, or
Phone: 1-800-692-7462	401-462-0311 (Direct RIte Share Line)
CHIP Website:	
Children's Health Insurance Program (CHIP) (pa.gov)	
CHIP Phone: 1-800-986-KIDS (5437)	
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov	Website: http://dss.sd.gov
Phone: 1-888-549-0820	Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: <u>Health Insurance Premium Payment (HIPP) Program Texas</u>	Utah's Premium Partnership for Health Insurance (UPP) Website:
Health and Human Services	https://medicaid.utah.gov/upp/
Phone: 1-800-440-0493	Email: upp@utah.gov
	Phone: 1-888-222-2542
	Adult Expansion Website: https://medicaid.utah.gov/expansion/
	Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
	CHIP Website: https://chip.utah.gov/
VERMONT- Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/
Department of Vermont Health Access	famis-select
Phone: 1-800-250-8427	https://coverva.dmas.virginia.gov/learn/premium-assistance/
	health-insurance-premium-payment-hipp-programs
	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/	Website: https://dhhr.wv.gov/bms/
Phone: 1-800-562-3022	http://mywvhipp.com/
	Medicaid Phone: 304-558-1700
	CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website:	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	-eligibility/
Phone: 1-800-362-3002	Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272) U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

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OMB Control Number 1210-0137 (expires 1/31/2026)

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Kansas BlueShield	Dental Plan Blue Cross & Blue Shield of Kansas 1133 SW Topeka Boulevard Topeka, KS 66612-0001	Phone: (800) 432-3990 E-mail: csc@bcbsks.com Web: www.bcbsks.com
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bhs	Employee Assistance Program BHS	Phone: (800) 327-2251 Web: portal.bhsonline.com Organization ID: GODDARDUSD



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