Section 125 Enrollment Information

Ann Krone (785) 225-6813 ▪ alkrone@ellsaline.org

All benefits and rates represented in this file are applicable only to the benefit period stated above. Benefits and rates are subject to change each benefit period. Please refer to your employer's benefits department for verification. Please note this brochure features *plan highlights only*. It is not a contract of insurance. The benefits are determined by the terms and conditions of the policy and certificates alone. Underwriting information and policy numbers are provided for each product. Please refer to your plan certificate(s), policies, and brochures for more detailed information. If a difference exists between this summary and the policy, the policy governs.

You may obtain a detailed brochure for each product at enrollment or by visiting https://secure.benebridge.com/assn/201. (see page 10 for more information and instructions)

Enrollment Dates & Times

Elementary School	High School
August 17th	August 17th
8:00am - 11:30am	12:30 - 4:00

Please sign up for a time slot with the link below

School Enrollment: Ell-Saline USD 307 Benefit Enrollment (signupgenius.com)

Blue Cross - Blue Shield

As a homegrown company, established in Kansas in 1942, BCBS of Kansas has been historically sensitive to the desires of Kansans. Their daily mission is to provide their members the highest level of service available. Blue Cross and Blue Shield of Kansas is especially proud to report that in their 103-county Kansas service area, 98 percent of physicians and general acute care hospitals, and 94 percent of other providers gladly accept a Blue Cross card. What's more, through BlueCard®, members have access to more than 90 percent of all doctors and 80 percent of hospitals in the U.S., as well as providers in more than 200 countries and territories worldwide. In addition to a large network, members have the freedom of seeing a specialist without needing a referral from their PCP and several resources available to them for a healthier lifestyle.

Heritage Companies

Pathway Financial Solutions along with OFG Financial Services, Inc., have partnered together with Heritage Companies to provide health insurance options. For more than thirty years, Heritage Companies has been helping individuals and businesses with their insurance needs. Their commitment to establish trust and long lasting relationships with their clients has led to a team that continues to advance and excel in the areas of service, standards and technology. With more than fifty years of experience between them, Mike Sanders, President, and Scott Lepley, Executive Partner, pledge to uphold the highest standards as professional insurance agents and advisors. It is their desire for Heritage to be your single point of contact for health insurance questions, claims issues, etc.

Scott Lepley

7926 E 171st Street

Belton, Missouri 64012

(800) 686-7260

(816) 322-6350

www.heritagekc.com

Ell-Saline USD 307 Medical Plan Comparison

Coverage	Blue Choice - Option 1
Annual deductible	**In-network**
~ Individual	$3,500
~ Family	$7,000
Coinsurance	20%
Coinsurance Max	
~ Individual	$2,500
~ Family	$5,000
Maximum out-of-Pocket (includes deductible)	
~ Individual	$6,350
~ Family	$12,700
Office Visit ~ Primary	$35 Copay
~ Specialist	$35 Copay
Inpatient Hospital	Deductible + Coinsurance
Outpatient Hospital	Deductible + Coinsurance
Emergency Services	$250 Copay; then Deductible + Coinsurance
Prescription Benefits	Results Rx
~ Tier 1	$15 Copay
~ Tier 2	$50 Copay
~ Tier 3	$75 Copay
~ Tier 4	$150 Copay
~ Tier 5	20% up to $250

Employee Cost of Health*	
Employee	$56.78
Employee + Spouse	$ 810.84
Employee + Child(ren)	$ 729.74
Family	$ 1,483.80

*Premium cost reflects the district paying $600.00 towards the full premium.

Ell-Saline USD 307 Corporate Plan

Coverage	Benefit
Annual deductible	
~ Individual	$750
~ Family	$1,500
1st Coinsurance	Single- (30% of next $2,750) - $825 Family- (30% of next $5,500) - $1,650
2nd Coinsurance	Single- (70% of next $2,850) - $1,995 Family- (70% of next $5,700) - $3,990
Maximum out-of-Pocket **(includes deductible, coinsurance, & copays)**	
~ Individual	$3,570 (750 + 825 + 1,995)
~ Family	$7,140 (1,500 + 1,650 + 3,990)
Office Visit ~ Primary	$35
~ Specialist	$35
Prescription Drug	$15.00/50.00/75.00 /150/20%

Any claim that falls under deductible and coinsurance will be handled in the following way:

* The first $750 single ($1,500 family) medical claims will be your responsibility
* The next $2,750 single ($5,500 family) of medical claims will be paid 70/30. In order to be reimbursed your 70% you will need to send your EOB (Explanation of Benefits).
* The next $2,850 single ($5,700 family) of medical claims will be paid 30/70.
* After the Out of Pocket Max has been met, BCBS of KS will pay 100%.
* This will make your annual total out-of-pocket on deductible and coinsurance: Single $3,570; Family $7,140

The important thing is to make sure you submit ALL your EOBs!

The address is: Corporate Plan Management
1220 SW Executive Dr
Topeka, KS 66615

If you have questions please call John Webb at Pathway Financial Solutions: 785-820-8161 or 888-756-6670.

Group Term Life Insurance

Ell-Saline USD 307 provides eligible employees the opportunity to purchase Voluntary Life Insurance on yourself, spouse and dependent children. You pay the total cost of this benefit through convenient payroll deductions. This benefit is offered through Reliance Standard Life Insurance Company. Below is a brief summary of coverage options. Contact Human Resources to update your beneficiary information.

https://secure.benebridge.com/brochures/common_ofg/rsl_term_life_100+.pdf - for rates and information.

Employee Coverage

- $25,000 to 5x annual salary or $500,000, whichever is less
- Purchased in increments of $5,000
- Guarantee issue at initial opportunity is $200,000 (under age 60); or $25,000 (age 60-64)
- Your coverage amount reduces to 50% at age 70
- Accelerated death benefit available if diagnosed with a terminal condition

Spouse Coverage

- $10,000 to $100,000, not to exceed 50% of employee election
- Purchased in increments of $5,000
- Guarantee issue at initial opportunity is $25,000
- Coverage terminates at age 70

Child Coverage

- 10 days to 6 months old: $1,000
- 6 months to age 19 (25 if full-time students): $10,000 or $20,000

Spouse and Dependent Child(ren) coverage can only be taken in conjunction with Employee coverage. Dependent coverage may not be taken on stand-alone basis. A spouse or child who is insured as an employee under this plan cannot also be insured as a dependent. If both you and your spouse are insured under this plan as employees, only one of you may insurer your child as dependents.

Guarantee Issue

Guarantee issue is the opportunity to purchase life insurance with no medical questions asked. Guarantee issue is offered at your initial opportunity only. If you enroll in the plan as a new hire, you will not have to provide medical evidence of insurability to qualify for coverage up to the Guarantee Issue Amount. You may need to provide evidence for amounts over the Guarantee Issue Amount. If you **do not** enroll as a new hire, and you decide you'd like coverage or increased coverage at a later time, you may be required to provide evidence of insurability. Your future opportunities to enroll in the plan may be limited, and you may be denied coverage for certain amounts.

Annual Enrollment Option—Employee Coverage Only

- If you are actively at work, are less than age 60 and are not currently enrolled in this plan you may elect $25,000. Evidence of Insurability is required for amounts that exceed $25,000.
- If you are actively at work, are less than age 60 and insured under this plan for at least 6 months you may enroll for an additional $25,000 each annual re-enrollment period without Evidence of Insurability. Additional amounts that exceed $25,000 will require Evidence of Insurability. The additional $25,000 available during the annual re-enrollment is limited to accumulative total of $100,000 of additional coverage or up to the Guarantee Issue Amount, whichever is less. Evidence of Insurability will be required for amounts that exceed the Guarantee Issue Amount. In no event will your benefit amount exceed the $500,000 plan maximum or be greater than 5 times your annual earnings.

Dental Coverage Information

With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to your overall well-being.

The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage (up to annual maximum benefit), with no deductible, for all services covered under the plan when an in-network dentist (Delta Dental Premier or Delta Dental PPO) is seen. If an out-of-network dentist is seen, the underlying contract applies including deductibles and coinsurance levels.

Unlimited Cleanings -The plan will allow for unlimited cleanings. This includes regular/prophylaxis cleanings and periodontal maintenance cleaning.

Coverage Level	Monthly Rates
Employee	$28.41
Family	$82.71

Dental Plan Benefits	
Annual deductible	$50 x 3
Diagnostic/preventive services Cleanings/fluoride	100%
Basic services Simple extractions/ fillings	50%
Major services Crowns/dentures/caps/bridge	50%
Annual Maximum Benefit	$1,500 per person per plan year
Orthodontics	Not Covered

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Please refer to the Description of Dental Care Coverage for complete coverage information, including exclusions and limitations. Coverage as described in the employer group's Description of Dental Care Coverage is binding on all parties and supersedes all other written or oral communications.

Vision Coverage Information– Vision Care Direct Plus

Vision Care Direct is a vision plan owned and operated by Private Practice Eye Care Providers (PPECP) who are members of their states' Independent Physician Associations (IPA). Currently, Vision Care Direct is made up of over 5,000 doctors in 45 states. Affordable Vision Plans that Your Eye Doctor Recommends.

Vision - https://secure.benebridge.com/brochures/common_ofg/vcd_rates_2-199.pdf

ALLOWANCE SUMMARY

EXAM	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Comprehensive eye-health vision examination includes refraction and dilation	100% after exam fee	$15	$50
FLEXIBLE EXAM OPTION: In the event that a member has an eye exam included with another plan, Vision Care Direct applies a credit to be used for other services or materials in lieu of a Vision Care Direct eye exam. An explanation will be provided to you by your provider at time of service in regards to the amount and how it was applied to your additional services or materials.			$0

SPECTACLE LENSES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 glass or plastic	100% after materials fee	$15	$50
Lined Bi-focal (FT28) in CR-39 glass or plastic	100% after materials fee	$15	$75
Lined Tri-focal (FT7x28) in CR-39 glass or plastic	100% after materials fee	$15	$100
Progressive (no-line multi-focal) in CR-39 glass or plastic	Up to retail price of lined tri-focal	$15 + Overage above allowance	$100
Upgrades and/or add-ons (anti-reflective coating, high-index, photochromic, etc.)	$0	Standard retail price	$0
POLYCARBONATE FOR KIDS (PK): Polycarbonate lenses for dependent children up to age 18	100% after PK fee	$25	$0

FRAMES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Frame allowance as indicated by desired plan toward standard retail price of any frame in the provider's office.	Up to $130	Overage above $130 allowance	$60

VCDPLUS LENS OPTION (In lieu of spectacle lens option above)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Bi-focal (FT28) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Tri-focal (FT7x28) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Progressive (up to a digital free form full back surface) in CR-39 glass or plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Upgrades and/or add-ons (high-index, photochromic, tint, etc.)	$0	Standard retail price	$0

CONTACT LENS (In lieu of glasses)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
ELECTIVE: Equal to frame allowance of desired plan, in lieu of frames and spectacle lenses. Can be used toward multi-focal contacts and contact lens fitting fees.	Up to $130	Overage above $130 allowance	Up to $80
MEDICALLY NECESSARY: Requires prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular aphakia and/or binocular aphakia.	Up to $250	Overage above $250 allowance	Up to $80

** Medically necessary contacts require prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; 2) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary.

Vision Plans & Rates	Employee	Employee +1	Employee/Children	Family
Exam Only	4.64	7.36	8.52	14.24
Gold Materials Only 130 PK	11.78	18.80	21.72	36.74
Gold Complete 130 PK	16.24	25.90	29.92	50.60

Flexible Spending Accounts

Why should you choose to participate in a Flexible Spending Account?

A Flexible Spending Account (FSA), also known as a reimbursement account, allows you to pay for a variety of out-of-pocket health care and dependent care expenses pre-tax. Putting money into a FSA before you pay taxes on it saves you money by lowering your taxable income. The result? You pay less in taxes each year. There are two types of FSAs available to you at USD 307:

1) **Healthcare Flexible Spending Account or Limited Purposed for High Deductible Plans**
   A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses. Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You may increase your spendable income by an average of 30% of your annual contribution with the tax savings. ($2,750 per plan year max, $550 rollover.)

2) **Dependent Care Flexible Spending Account**
   A dependent care account (DCA) is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work. ($5,000 per plan year max, no rollover.)

Increase Your Take Home Pay	With FSA	Without FSA
Annual Gross Pay	$30,000	$30,000
FSA Contributions	-$2,400	$0.00
Taxable Income	$27,600	$30,000
Deductions From Pay (Fed Inc Tax (assumes 30% tax bracket), FICA Tax, State Inc Tax)	-$8,280	-$9,000
Healthcare Expenses	$0.00	-$2,400
After-Tax Take Home Pay	$19,320	$18,600
Annual Tax Savings	$720	$0.00

REMINDER - Always request a DETAILED RECEIPT from the provider, even when using the FSA Debit Card. The IRS requires you keep them for your tax records, and you will also need them if your FSA vendor requests substantiation that an expense is a qualified FSA expenditure.

Account Access as Mobile as You Are!

Have the account information you need, right when you need it most. The Bay Bridge Administrators mobile app makes it easy to manage your flexible spending accounts on the go. The secure mobile app gives you access to your FSA with the following features:

- Free application available for Apple or Android smart devices
- Gain instant access by entering the same username and password that you create on the WealthCare Portal
- View account balances and transaction history
- Attach receipts by taking a photo
- Add or edit text message alerts
- Contact the administrator for assistance

Download Bay Bridge Administrators from the Apple App Store or Android Marketplace Today!

Medical Expense Reimbursement - https://secure.benebridge.com/brochures/common_ofg/med_reim.pdf
Dependent Care - https://secure.benebridge.com/brochures/common_ofg/dep_care.pdf

Short Term Disability Insurance

In this time of insurance of on everything you own (your house, your car, your boat) and on your health, many people completely disregard one of their most valuable assets: their income.

The disability income protection offered in your Section 125 plan by Reliance Standard Life Insurance Company lets you insure a portion of your income should you become disabled and not able to work.

Some of the Plan Features

- Enrollment will insure 66 2/3% of your salary (rounded up to the next largest $100 amount) not to exceed $7,500 monthly benefit
- You may elect an elimination period of 14, 30, 60, or 90 days for Sickness or Injury.
- Benefits are paid monthly for a period determined by subtracting the waiting period elected by you from 26 weeks.
- Benefits are coordinated with your employer paid "sick leave." If you are receiving "sick leave" benefits from your employer, the disability benefit will be reduced. This plan does not require you to take your "sick leave."
- The disability income plan pays a benefit of one doctors visit, an emergency room visit, & a hospital confinement benefit. (restrictions apply)

Disability Insurance - https://secure.benebridge.com/brochures/common_ofg/rsl_disability.pdf

Individual Cancer and Specified Disease Insurance

When Cancer Strikes. . .

~ Expenses increase. . . travel & lodging to and from treatment, medication, co-payments, special diets, and treatment not covered by health insurance, etc.

~ Income decreases. . . missed work for both you and your spouse (will you be able to afford to have your spouse with you when you have to go to treatment?)

PLAN PAYS YOU!!!

- Major medical pays the doctor and hospital
- This Plan pays money directly to you and you can use the money any way you want

Highlights. . .

* Pays regardless of other coverage
* Covers certain transportation and lodging
* Wellness Benefits
* Donor Benefits
* In and out of hospital benefits
* Many benefits have no lifetime maximum
* Portable (take it with you)
* Renewable for life
* Premiums for this policy are based on issue age on the effective date of the policy. You lock in your age class for the life of the policy. The premium for this policy and rider if selected may change but will not change because you attain the next premium rate age classification.

Individual Cancer - https://secure.benebridge.com/brochures/common_ofg/cancer.pdf - for rates and details

Short Term Disability Insurance: this is not a contract of insurance. The terms and conditions of coverage are set forth in Policy Number G 647679, on Policy Form Number LRS-9384-0107. The Policy is subject to the laws of the state in which it is issued.

Individual Accident Insurance

WHEN AN ACCIDENT HAPPENS. . .

Your Expenses Increase . . . for treatments, medication, co-payments and deductibles.
Your Income Decreases due to missed work.

All the while your everyday expenses do not stop. House payments or rent, utilities, credit card bills, and all other monthly obligations continue on their regular schedule.

PLAN PAYS YOU!!!
The Plan pays money directly to you and you can use the money any way you want.

Highlights. . .
The Bronze, Silver, and Gold Options includes benefits for Accidental Death and Dismemberment, Dislocations and Fractures, Accident Hospital Indemnity, Ambulance, Accident Medical Expense.

*Pays regardless of other coverage
*Portable (take it with You)
*Guaranteed Renewable to age 70
*In– and out-of-hospital benefits

Individual Accident - https://secure.benebridge.com/brochures/common_ofg/accident.pdf - for rates and details

Heart Attack, Heart Disease, Stroke Insurance

With Optional Benefits for Intensive Care and Cancer First Diagnosis

WHEN YOU EXPERIENCE A HEART ATTACK, STROKE OR HEART DISEASE
WHAT HAPPENS TO YOUR FINANCIAL SITUATION?

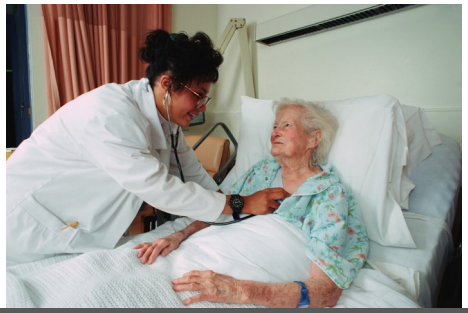
~ Your expenses increase. . . for medications, co-payments, deductibles and other medical costs.
~ Your recovery could take weeks or months resulting in lost wages.

PLAN PAYS YOU!!!
The Plan pays money directly to you and you can use the money any way you want.

Highlights. . .

* Pays regardless of other coverage
* Portable (take it with you)
* In and out of hospital benefits
* Renewable for life
* Premiums for this policy are calculated at age at issue class as of the effective date of the policy. You lock in your age class for the life of the policy. The premium for this policy and riders, if selected, may change but will not change because you attain the next premium rate age classification.

Individual Heart & Stroke - https://secure.benebridge.com/brochures/common_ofg/heartstroke.pdf - for details



Monthly Premium Rates Per Unit Base Policy

Issue Age Band	Employee	Employee + Spouse	Employee + Child(ren)	Family
Under 30	3.17	6.34	4.14	7.31
30 - 44	10.26	20.52	11.23	21.49
45 - 59	23.23	46.46	24.19	47.42
Over 59	46.14	92.27	47.10	93.24

Individual Accident Insurance is underwritten by Humana Insurance Company; Policy Form HIC-ACC-POL-KS 7/09.

Group Critical Illness Insurance is underwritten by Humana Insurance Company; Policy Form HIC-GP-CI 10/11.

InfoArmor– Identity Theft

Identity & Credit Monitoring

Credit Scores & Reports

Password Protection

Social Media Reputation Monitoring

Wallet Protection

Digital Identity Report

Privacy Advocate Remediation

$1,000,000 Identity Theft Insurance Policy

Solicitation Reduction

Privacy Armor	
Employee Only	$7.95
Family	$13.95

Privacy Armor Plus	
Employee Only	$9.95
Family	$17.95

InfoArmor—https://secure.benebridge.com/brochures/common_ofg/infoarmor_plus.pdf

KNEA Dues

Teacher Total for the year is $805.20

($67.10 per month on 12 month deduction)

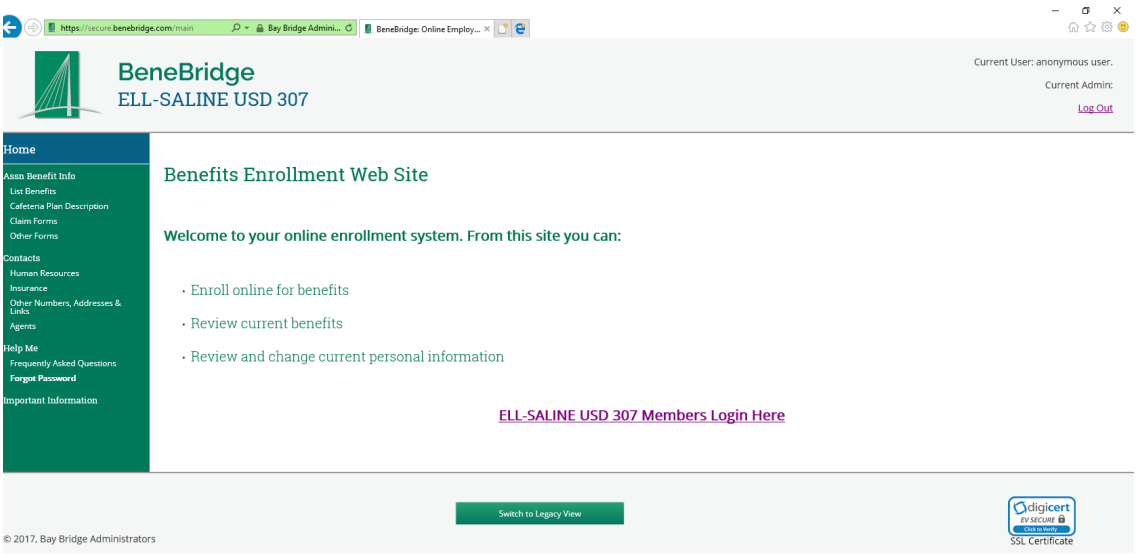
If you have specific questions, contact

Susan Nelson - MS/HS or Christina Jacquart - Elementary.

The previous information is for summary purposes only. If you would like to see a full brochure of the individual product, go to the following link & follow these instructions below.

Ell-Saline USD 307 BeneBridge web page: https://secure.benebridge.com/assn/201

On the left side click "List Benefits" for the individual products full brochure.
If you would like to be able to log in to view what you are currently enrolled in, please follow the instructions in the self-enrollment guide.



Retirement Reality*

⇒ *2 out of 3 retirees are unable to maintain standard of living in retirement*
⇒ *56% of Americans have less than $10,000 saved for retirement*
⇒ *$6.6 trillion retirement income gap for those between the ages of 32-64*
⇒ *38.3 million working-age households (45%) have $0.00 retirement account assets*
⇒ *50% of retirees retire earlier than planned*
⇒ *75% expect to work in retirement; 25% actually can and do*
⇒ *80% of working households have retirement savings less than 1x their annual income*

With the options of a 403(b) plan, you have the opportunity to begin the process of saving for your retirement future.

It's easy to do:

- Set up your account with one of the approved providers. They will assist in determining an investment strategy that best fits your investment objective risk tolerance & financial circumstance.
- Determine the amount of money you want to deduct from your check on a per-pay period basis. The money will be withheld from your check and invested into your established account.

It's really that easy! Contact one of the approved providers to get started!

** Sources: Center for Retirement Research, Pension Rights Center, National Institute on Retirement Security, Time.com, "The Retirement Reality Gap", Money Magazine April 15, 2014.*

403(b) Retirement Plan Highlights

Contributions

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. There are no employer contributions.
- Pre-tax contributions are deducted **before** 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 **after** 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 transfer benefits from a former employer's eligible retirement plan into this plan.

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 ($19,500 in 2021).
- If you are age 50 or older you can contribute a "catch-up" contribution of up to $6,500 (2021).

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.

Investments

Where are my contributions invested?

- You may choose the 403(b) custodial account or annuity contract you want from the list of approved investment providers and 403(b) investment products located on the Bay Bridge website, https://www.bbadmin.com/sfr_select_employee.php?id=201

How are my contributions invested?

- You select how you want your contributions to be invested from among the investment options available under each approved investment provider's product.
- Your investment provider's custodial account or annuity contract will determine how often you may change your investment mix.

Notes

Notes

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

Ann Krone
412 E. Anderson
Brookville, Kansas 67425
(785) 225-6813
akrone@ellsaline.org

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

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: **Ell-Saline Public Schools USD 307**
Employer EIN: **48-0725851**
Employer Address: **412 E. Anderson**
Brookville, KS 67425
Employer Phone Number: **(785) 225-6813**

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

- As your employer, we offer a health plan to:
  - ☑ Some employees. Eligible employees are
    All full-time eligible employees working 30 or more hours per week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Legal spouse and dependents

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

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing 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).

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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.
To request special enrollment or obtain more information, contact Ann Krone at 412 E. Anderson, Brookville, Kansas 67425, (785) 225-6813, akrone@ellsaline.org.

NOTICE OF PRIVACY PRACTICES

Ell-Saline Public Schools USD 307
412 E. Anderson
Brookville, Kansas 67425
(785) 225-6813

Privacy Official:
Ann Krone
412 E. Anderson
Brookville, Kansas 67425
(785) 225-6813
akrone@ellsaline.org
Effective Date: 07/01/2020

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share

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

- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Ann Krone
  412 E. Anderson
  Brookville, Kansas 67425
  (785) 225-6813
  akrone@ellsaline.org
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICES

Enrollment Notice
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 this plan. Therefore, the following deductibles and coinsurance apply: $5000 deductible (in-network) and 0% coinsurance (in-network) and $5000 deductible (out-of-network) and 20% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (785) 225-6813.

Annual Notice
Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (785) 225-6813 for more information.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the USD 307 Ell-Saline Welfare Benefit Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (785) 225-6813.

EMPLOYER'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

For additional state information or for more information on special enroller rights, you can contact either:

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

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

MICHELLE'S LAW NOTICE

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the USD 307 Brookville group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of USD 307 Ell-Saline group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the USD 307 Brookville group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the USD 307 Ell-Saline group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The USD 307 Ell-Saline group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary
- Student must be enrolled in the plan immediately prior to the first day of the medically necessary leave of absence.

To obtain additional information, please contact:

Ann Krone
412 E. Anderson
Brookville, Kansas 67425
(785) 225-6813
akrone@ellsaline.org

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from USD 307 Ell-Saline 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 307 Ell-Saline and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. USD 307 Ell-Saline has determined that the prescription drug coverage offered by the USD 307 Ell-Saline Welfare Benefit 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 307 Ell-Saline coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current USD 307 Ell-Saline coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with USD 307 Ell-Saline 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 call Ann Krone at (785) 225-6813. 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 307 Ell-Saline 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: 07/15/2020
Name of Entity/Sender: Ell-Saline Public Schools USD 307
Contact--Position/Office: Ann Krone
Address: 412 E. Anderson, Brookville, Kansas 67425
Phone Number: (785) 225-6813

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURES

Genetic Information Nondiscrimination Act of 2008
The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GENERAL NOTICE OF COBRA RIGHTS

(For use by single-employer group health plans)
Continuation Coverage Rights Under COBRA

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

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

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Ann Krone
412 E. Anderson
Brookville, Kansas 67522
(785) 225-6813
akrone@ellsaline.org

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Ell-Saline Public Schools USD 307
Ann Krone
412 E. Anderson
Brookville, Kansas 67425
(620) 543-2258
akrone@ellsaline.org

GENERAL FMLA NOTICE

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

2 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Requesting Leave
Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.
Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

USERRA NOTICE

Your Rights Under USERRA

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

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

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

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

C. Right To Be Free From Discrimination and Retaliation
If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

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

D. Health Insurance Protection

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

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USADOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Refer to this list when you need to contact one of your benefit vendors.

For general information contact Personnel Services.

Employee Customer Service Contacts

Company	Website	Phone Number
Blue Cross Blue Shield of Kansas	www.bcbsks.com	800-432-3990
Delta Dental of Kansas	www.deltadentalks.com	800-234-3375
Vision Care Direct	visioncaredirect.com	877-488-8900
Security Benefit	www.securityflex.com	888-473-5572

Benefit Consultant– Medical

Company	Contact	Phone Number
Heritage Companies	www.heritagekc.com	816-322-6350

Benefit Consultant

Company	Contact	Phone Number
Pathway Financial Solutions	John Webb, Eddie Balluch, & Travis Schroeder pathway@ofgfinancial.com	785-820-8161

Tax Sheltered Accounts - 403(b) & Roth 403(b)

Company	Agent & Phone	Agent & Phone
Security Benefit Life	John & Kelli Webb 888-756-6670 Jordan Webb 888-756-6670	Eddie Balluch 888-756-6670 Travis Schroeder 888-756-6670
LPL Financial, LLC	Troy Jennings 785-827-3606 Randy Krug 785-483-6581 J.J. O'Connor 785-827-3606	Robert Schmidt 785-827-3606 Cal Smith 785-827-3606 Steven Stein 785-827-3606
American Fidelity	1-800-365-1167	

KPERS

Company	Contact	Phone Number
Kansas Public Employees Retirement System	www.kpers.org	888-275-5737

Benefits Provided By

Pathway Financial Solutions, Salina, Kansas

Pathway Financial Solutions is a full service branch office of Topeka based OFG Financial Services, Inc. Since 1992, John and Kelli Webb have worked with school districts to provide comprehensive Sec. 125 benefits and retirement planning services to thousands of public school employees. In 2014 Jordan Webb joined our organization, then Eddie Balluch in 2016, Travis Schroeder in 2019 and Brad Veenendaal in 2021. This has allowed us to further expand our service capabilities. In addition to these five financial professionals, we have additional customer service support with Daniel Crotinger, Client Service Specialist, who joined our firm in 2019, and two additional assistants, Donella Hughes, who has been with us for more than 10 years, and Amanda Hanson, who also joined our firm in 2021. Jami Simmons, who will continue to assist with benefit enrollments, is now leading our office in individual insurance solutions. Our branch office currently services Sec. 125 and voluntary 403(b) plans in over 30 school districts. We also service employer matching 403(b) plans, employer prefunded 403(b) plans, and employer post retirement funding 403(b) plans in over 20 school districts. Each member of our staff and their families were born and raised in Kansas with deep ties to our communities and to our local schools. We strive to give back to Kansas through our memberships in various organizations, and through volunteering in our community, churches, and schools.

John Webb, Kelli Webb, Jordan Webb, Eddie Balluch, Travis Schroeder & Brad Veenendaal

120 S Santa Fe Ave
Salina, Kansas 67401
(888) 756-6670
(785) 820-8161
pathway@ofgfinancial.com

OFG Financial Services, Inc., Topeka, Kansas

Beginning in 1975, OFG Financial Services, Inc. started offering "Cafeteria" fringe benefit plans to public schools. This was cutting edge as it was before the Sec. 125 "Cafeteria" Fringe Benefit Plan law was finalized in 1978. Beginning with one school district in 1975, we have grown, and now provide Sec. 125 Plan benefits and compliance for numerous public schools and corporations in Kansas, Oklahoma, Missouri and Texas.

Our Sec. 125 plan business in the public school market has become the basis for significant growth in the Sec. 403(b) market. The servicing of, and our visibility in providing Sec. 125 benefits to our public school employees, provides a natural extension into the Sec. 403(b) market.

OFG Financial Services, Inc. is a proud sponsor of KASBO, USA, KNEA, KASB and the Kansas Teacher of the Year program.

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