



Keystone Learning

Keystone Learning Services | 500 E. Sunflower Blvd. | Ozawie, KS 66070 | Main Office – 785-876-2214



DISCLAIMER

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by your company.

If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract

The information in this booklet is proprietary. Please do not copy or distribute to others.

Created by Holmes Murphy & Associates



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Customer Service Contact Information

MEDICAL:

Aetna

Customer Service - (800) 872-3862

Website - www.aetna.com

DENTAL:

Delta Dental of Kansas

Customer Service - (800) 234-3375

Website - www.deltadentalks.com

VISION:

Surency

Customer Service - (866) 818-8805

Website - www.visioncaredirect.com

FLEXIBLE SPENDING ACCOUNT(FSA) ADMINISTRATION:

FlexMade Easy

Customer Service - (855) 615-3679

Customer Service Email - info@flexmadeeasy.com

VOLUNTARY TERM LIFE:

Guardian

Customer Service - (800) 348-4512

Email - maryland@essdack.org

SHORT-TERM DISABILITY

Dearborn National

Customer Service - (877) 523-0176

Customer Service Email - talt@benefits-direct.com

CRITICAL ILLNESS & ACCIDENT INSURANCE

UNUM

Customer Service - (866) 679-3054

Website - www.unum.com

PERMANENT LIFE INSURANCE WITH LONG TERM CARE BENEFITS

Combined Life

Customer Service - (877) 523-0176

Customer Service Email - info@benefits-direct.com

IDENTITY THEFT INSURANCE

InfoArmor

Customer Service - (877) 523-0176

Customer Service Email: info@benefits-direct.com

403(B)

Security Benefit Life - Leasa Huffman

(785) 267-6556

Email Address - leasahuffman@ofgfinancial.com

American Fidelity Assurance Co. - Steve Schwartz

(785) 232-8100

Email Address - steve.schwartz@americanfidelity.com

Lincoln Investment Planning

Customer Service - (800) 242-1421

GENERAL NON-MEDICAL BENEFITS ASSISTANCE

Avant Specialty Benefits - Tracy League

Direct Phone - (816) 857-7836, Toll-free - (866) 574-6282

Direct Email - tleague@avantsb.com



WHO IS ELIGIBLE?

You are eligible for Keystone Learning Services benefits if you are a full-time employee (working 30 or more hours per week). You will be eligible to enroll in benefits the first of the month following 30 days.



HOW TO ENROLL

The first step is to review the benefit enrollment packet materials and then schedule an appointment to meet with a benefit counselor on designated days to ask questions and make your elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.



WHEN TO ENROLL

Keystone Learning Services has an annual enrollment. All benefit elections will be effective for the entire 12 month plan year beginning on July 1, 2017 for medical coverage. All other coverages begin September 1, 2017. 403(b) plan elections will be captured separately from all other benefit offerings.



HOW TO MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period (qualified change in status rule does not apply to 403(b) plan administration). Qualified changes in status include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partners benefits or employment status. See HIPAA Special Enrollment Rights later in this packet for notification requirements.

MEDICAL INSURANCE



In-Network Benefits	Plan 13 \$1,000 Deductible - POS	Plan 53 \$5,000 Deductible - POS	Plan Q04 / HSA \$2,600 High Deductible - POS
Deductible	\$1,000 / Individual \$2,000 / Family	\$5,000 / Individual \$10,000 / Family	\$2,600 / Individual \$12,000 / Family
Coinsurance	80% / 20% (Plan pays 80%; individual pays 20% after deductible to coins. max.)	50% / 50% (Plan pays 50%; individual pays 50% after deductible to coins. max.)	100% / 0% (Plan pays 100%; individual pays 0% after deductible to coins. max.)
Coinsurance Maximum	\$3,000 / Individual \$6,000 / Family	\$6,3500 / Individual \$12,700 / Family	\$3,500 / Individual \$7,000 / Family
Office Visit Copays	\$25 / visit – PCP \$50 / visit - Specialist	\$30 / visit – PCP \$60 / visit - Specialist	100% covered after deductible
Preventive Care	100% Covered; deductible waived	100% covered; deductible waived	100% covered; deductible waived
Emergency Room	EE pays 20% after \$200 copay after deductible	EE pays 50% after \$200 copay after deductible	100% covered after deductible
Urgent Care	\$50 copay; deductible waived	\$50 copay; deductible waived	100% covered after deductible
Hospital Stay	EE pays 20% after deductible	EE pays 50% after deductible	100% covered after deductible
Outpatient Surgery	EE pays 20% after deductible	EE pays 50% after deductible	100% covered after deductible
Rx – Aetna Value Plus Open Formulary	Value Generic - \$3 Preferred Generic - \$12 Preferred Brand - \$50 Non-preferred - \$75 Preferred & Non-Preferred Specialty – 20% to max of \$150 or \$250	Value Generic - \$3 Preferred Generic - \$12 Preferred Brand - \$40 Non-Preferred - \$65 Preferred & Non-Preferred Specialty – 20% to max of \$150 or \$250	After deductible: Value Generic - \$3 Preferred Generic - \$12 Preferred Brand - \$40 Non-Preferred - \$65 Preferred & Non-Preferred Specialty – 20% to max of \$150 or \$250
RX – Mail Order	2.5x retail copay	2.5x retail copay	2.5x retail copay after deductible
Dependent Coverage	Eligible children covered to age 26	Eligible children covered to age 26	Eligible children covered to age 26
Lifetime Maximum	Unlimited	Unlimited	Unlimited

*Refer to Carrier Summary of Benefits and Coverage, under Annual Notices, for more details.

Complete either the front or back
whichever option pertains to you.

Aetna HEALTH CARE
ELECTION FORM FOR
NORTHEAST KANSAS EDUCATION SERVICE CENTER
Effective 9/01/2017 – 6/30/2018

_____ ***Option 1:** \$1,000 per person/\$2,000 two-or-more persons deductible, 80/20 coinsurance to \$3,000 per person/\$6,000 two or more persons.

_____ Employee	\$ 690.83 -\$465=\$225.83
_____ Employee/Child(ren)	\$1,398.75 -\$465=\$933.75
_____ Employee/Spouse	\$1,484.43 -\$465=\$1019.43
_____ Family	\$2,192.34 -\$465=\$1,727.34

_____ **Option 2:** \$5,000 per person/\$10,000 two-or-more persons deductible, 50/50 coinsurance to \$6,350 per person/\$12,700 two or more persons.

_____ Employee	\$ 518.83 -\$465=\$53.83
_____ Employee/Child(ren)	\$1,049.88 -\$465=\$584.88
_____ Employee/Spouse	\$1,114.79 -\$465=\$649.79
_____ Family	\$1,645.85 -\$465=\$1,180.85

_____ **Option 3: High Deductible with Health Savings Plan:** \$2,600 per person/\$5,200 two-or-more persons deductible. After deductible has been met all eligible expenses will be paid at 100% except prescription drugs which will have co-payments until another \$900 per out of pocket per person is reached.

_____ Employee	\$ 656.51 -\$465=\$191.51
_____ Employee/Child(ren)	\$1,329.27 -\$465=\$864.27
_____ Employee/Spouse	\$1,410.70 -\$465=\$945.70
_____ Family	\$2,083.45 - \$465=\$1,618.45

Signature

Date

Printed Name

ID Number from card

IF YOU DO NOT ELECT
TO TAKE A HEALTH PLAN
OPTION BACK OF THIS
FORM MUST BE SIGNED.
THANKS

HEALTH SAVINGS ACCOUNTS – PROS AND CONS



The Health Savings Account (HSA) is a growing trend in health care. They have been embraced by over 10 million Americans since first established by law in 2003.

Advantages

Health Savings Accounts offer a way to save for – and pay for – healthcare (medical, prescription, dental, vision) expenses. There are many advantages to having a Health Savings Account, including:

- **Others can contribute to your HSA.** Contributions can come from various sources, including you, your employer, a relative and anyone else who wants to add to your HSA.
- **Pre-tax contributions.** Contributions made through payroll deposits (through your employer) are typically made with pre-tax dollars, which means they are not subject to federal income taxes. In most states (including KS and MO), contributions are not subject to state income taxes either. Your employer can also make contributions on your behalf, and the contribution is not included in your gross income.
- **Tax-deductible contributions.** Contributions made with after-tax dollars can be deducted from your gross income on your tax return, which means you may owe less tax at the end of the year. Contributions to your HSA can be made any time during the calendar year and up to April 15 of the following tax year. You can make regular contributions throughout the year, or make one lump-sum contribution whenever it's convenient.
- **Tax-free withdrawals.** Withdrawals from your HSA are not subject to federal (or in most cases, state) income taxes if they are used for qualified expenses (medical, prescription, dental and vision).
- **Tax-free earnings and interest.** Any interest or other earnings on the assets in the account are tax free.
- **Funds roll over.** If you have money left in your HSA at the end of the year, it rolls over to the next year (unlike an FSA which is subject to the "use-it-or-lose-it" rule). The funds in the account continue to build over time, with no maximum.
- **You can budget how much to contribute.** The IRS permits you to change, start and stop the amount of your pre-tax payroll contributions as often as monthly.
- **Portable.** The money in your HSA remains available for future qualified healthcare expenses even if you change health insurance plans, change employers or retire. Funds left in your account continue to grow tax free.
- **Convenient.** Most HSAs issue a debit card, so you can pay for your prescription medication and other expenses right away. If you wait for a bill to come in the mail, you can call the billing center and make a payment over the phone using your debit card. And, you can use the card at an ATM to access cash.
- **Reduced premiums.** HSAs go hand-in-hand with HDHPs, so monthly premiums are generally significantly less than if you have a low deductible health plan.

- **Ownership.** The employee owns the account and has full control over how the account is used and invested.
- **Flexibility.** You can use the funds in your account to pay for the expenses (medical, prescription, dental and vision) of yours, your spouse and your tax-dependent children even if they are not enrolled on your insurance plans.

Disadvantages

HSAs also have a few disadvantages, including:

- **High deductible requirement.** You must be enrolled in a qualifying High Deductible Health Plan (HDHP) before you can open and establish an HSA. Even though you are paying less in premiums each month, it can be difficult – even with money in an HSA – to come up with the cash to meet a high deductible.
- **Unexpected healthcare costs.** Your healthcare costs could exceed what you had planned for, and you may not have enough money saved in your HSA to cover expenses.
- **Pressure to save.** You may be reluctant to seek healthcare when you need it because you don't want to use the money in your HSA account.
- **Taxes and penalties.** If you withdraw funds for non-qualified expenses before you turn 65, you'll owe taxes on the money plus a 20% penalty. After age 65 (or if you become disabled), you'll owe taxes but not the penalty.
- **Recordkeeping.** You have to keep your receipts to prove that withdrawals were used for qualified health expenses.
- **Additional tax forms.** Your HSA bank will provide you two tax forms you will need to file your taxes and save with your tax return. IRS form 8889 is filed with your income taxes to report year-to-date contributions and distributions from your HSA. IRS form 1099-SA provides you with the total distributions that were made from your HSA. IRS form 5498-SA reports the contributions made to your HSA in that particular tax year.
- **Fees.** Some HSAs charge a monthly maintenance fee or a per-transaction fee, which varies by institution. While typically not very high, the fees do cut into your bottom line. Sometimes these fees are waived if you maintain a certain minimum balance. Oftentimes, the employer will cover the cost of the monthly fees for their full-time employees.
- **Contribution limits.** The IRS sets contribution limits that determine how much you and/or your employer can contribute to your HSA each year. For 2016, the maximum contribution amounts are \$3,350 for self-only coverage and \$6,750 for family coverage. You can add up to \$1,000 more as a "catch-up" contribution if you are age 55 or older at the end of your tax year.
- **Responsibility.** You as the accountholder are required to be knowledgeable of the IRS rules regarding HSA eligibility, contributions and distributions.

A Health Savings Account can be a great choice for people who wish to limit their upfront healthcare costs while saving for future expenses. For additional information, please see **IRS Publication 502** for a listing of hundreds of qualified medical, prescription, dental and vision expenses. Also, **IRS Publication 969** goes into more detail on the eligibility, contribution and distribution rules associated with HSAs.

Short Term Disability Insurance	Cancer	Vision
<u>Dearborn National</u> Premium based on option 1 st day accident/ 4 th day sickness 8 th day accident/ 8 th day sickness 15 th day accident/ 15 th day sickness 31 st day accident/ 31 st day sickness	<u>Loyal American</u> Employee, Single Parent and Family Coverage available 3 levels of coverage Premium based on option	<u>Surency-Eye Med</u> Emp. -\$6.91 Emp./Child(ren)-\$13.82 Emp./Sp-13.13 Family-\$20.37 In Network Doctor Service Wellness Exams Contact Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses Frames
Voluntary Term Life	Critical Illness	Accident
<u>Guardian</u> Premiums based on age and amount of coverage. Coverage available for employee, spouse and dependents Portable with age restrictions Accelerated Life Benefit	<u>UNUM</u> Premium based on options Face amounts from \$5,000 to \$50,000 in increments of \$1,000 Spouse coverage available from \$5,000 to \$30,000 In Increments of \$1,000 Dependents are automatically covered at 25% Benefit paid upon diagnosis of one of the listed critical illnesses.	<u>UNUM</u> Employee, spouse and dependent coverage Monthly Premium Employee - \$15.04 Employee + Spouse - \$24.32 Employee + Child - \$28.08 Family - \$37.36 No Health Questions Plan is Portable Sickness Hospital Confinement Benefits
Dental	Term & Permanent Life Ins.	Identity Protection
<u>Delta Dental</u> Employee- \$34.45 Employee +Spouse – \$68.19 Employee +Child(ren)-\$67.55 Family-\$114.69 Diagnostic, Preventive and basic	<u>Benefit Direct</u> Life Insurance w/ Guaranteed Rates to age 120 Long Term Protection to age 120 Up to \$75,000 for employees and NO HEALTH QUESTIONS	<u>Privacy Armor</u> Privacy Armor offers consumers a comprehensive, proactive identity theft defense Employee only - \$7.95 Family Coverage - \$13.95

Medical Flex and Dependent Care Flex Accounts

The Medical Flex and Dependent Care Flex Accounts are offered through Flex Made Easy and will be employee paid BEFORE taxes. Please remember that new elections need to be made every year as election amounts do not roll from year to year.

If you are enrolling in the Flexible Spending Accounts for the first time you will receive detailed information about accessing your account online once enrollment is complete.

Summary of Dental Plan Benefits

KEYSTONE LEARNING SERVICES

Group #53241

Effective for September 1, 2017

Maximum Benefit(s) Per Person:

The Maximum Benefit for all Covered Services for each Enrollee in any one Calendar Year is: One Thousand Five Hundred Dollars (\$1,500.00).

Deductible Limitations:

Coverage for diagnostic and preventive services is not subject to any deductible amount. For all other covered benefits, the Calendar Year deductible is:

\$50 x 3

Eligible Children Ages:

Children are eligible to age twenty-six (26).

Monthly Rates:

Employee:	\$34.45
Employee + Spouse:	\$68.19
Employee + Child(ren):	\$67.55
Family:	\$114.69

Benefit % Paid
Delta Dental PPO Premier / Non-participating

DIAGNOSTIC & PREVENTIVE (Not subject to deductible)

100%	100%	Diagnostic:	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • Oral evaluations – once (1) each six (6) months. • <u>Biteewing x-rays</u> – bitewings once (1) each six (6) months for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once each five (5) years.
100%	100%	Preventive:	Provides for the following: <ul style="list-style-type: none"> • <u>Prophylaxis</u> (Cleanings) - once (1) each six (6) months. • <u>Topical Fluoride</u> – once (1) each six (6) months for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

BASIC (Subject to Deductible)

90%	80%	Ancillary:	Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
90%	80%	Oral Surgery:	Provides for extractions and other oral surgery including pre and post-operative care.
90%	80%	Regular Restorative:	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
90%	80%	Endodontics:	Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
90%	80%	Periodontics:	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. b. Surgical periodontal procedures.

MAJOR (Subject to Deductible)

60%	50%	Special Restorative:	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
60%	50%	Prosthodontics:	a. Includes bridges, partial and complete dentures. b. Repairs and adjustments of bridges and dentures.
60%	50%		

ORTHODONTICS (Subject to Deductible)

None	None	Orthodontics:	Orthodontic appliances and treatment.
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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 Agreement to Provide Dental Benefits (contract) is binding on all parties and supersedes all other written or oral communications.



Summary of Proposed Vision Plan Benefits

KEYSTONE SERVICE CENTER

Effective for September 1, 2017

SERVICES	IN NETWORK MEMBER COST	OUT OF NETWORK ALLOWANCES	FREQUENCY
Vision Examination with Dilation as Necessary Retinal Imaging	\$10 Remaining balance over \$39	\$35 Remaining balance over \$39	Once every 12 months
Contact Lens Fit and Follow-Up: (Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed.) Standard -spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.) Premium -all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	Up to \$55 10% off Retail	Not Covered Not Covered	Once every 12 months Once every 12 months
Frames: Any available frame at provider location.	\$130 Allowance	\$65	Once every 12 months
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular	\$10 Copay \$10 Copay \$10 Copay \$10 Copay	\$25 \$40 \$55 \$55	Once every 12 months
Lens Options: Standard Polycarbonate UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Premium Progressive (Add-on to Bifocal) Other Add-Ons and Services	Adults: \$40, Dependents: under 19 \$0 \$15 \$15 \$15 \$45 \$65 \$65 + 80% of Retail, less \$120 20% off Retail Price	\$25 \$25 Not Covered Not Covered Not Covered Not Covered \$40 \$40 Not Covered	Once every 12 months
Contact Lenses: (Contact lens allowance includes materials only) (Allowance not available if eyeglass lenses are elected) Conventional Disposable Medically Necessary	\$130 allowance, 15% off balance over \$130 \$130 allowance \$0	\$100 \$100 \$200	Once every 12 months

Service frequencies are computed by date of service, not calendar year.

Monthly Rates:

Employee:	\$6.91
Employee + 1/Spouse:	\$13.13
Employee + Child(ren):	\$13.82
Family:	\$20.37

NOTE: Rates are guaranteed for three (3) years.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

This is a Summary of benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.



Get the convenience you need and the provider choices you want with your Surency Vision plan.

With access to over 73,000 providers nationwide, finding a **Surency Vision** provider is easy and one less task to worry about. **Surency Vision** combines Eyemed Vision Care's extensive provider network with **Surency's** strong customer focus - the kind of focus you deserve.

Locate a Surency Vision provider at surency.com or download the Surency Vision mobile app (available for Apple & Android)

Search for a provider by:

- Zip Code
- Provider/Retail name
- Hours and scheduling
- Services
- Products
- Brands



The biggest network and the most choice. Because more is more.

Surency Vision is offered through Surency Life & Health Insurance Company ("Surency"). Claims processing, claims service and network administration for Surency Vision are handled through an agreement with EyeMed Vision Care, LLC. Surency has been selected by your employer to provide your group vision coverage. We are pleased to bring these important benefits to you and any eligible dependents you have enrolled for coverage.

This Summary of Vision Plan Benefits describes the essential features of your group vision coverage. This Summary of Vision Plan Benefits is a summary of benefits only and does not bind Surency to any coverage. All benefits are paid according to the terms, conditions and provisions of your employer's Agreement with Surency, which is binding on all parties and supersedes all other written or oral communications.

Additional Value Added Savings:

- Members will receive a 20% discount on items not covered by the plan's in-network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to the cost of provider services or contact lenses. Retail prices may vary by location.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/Exclusions:

- Allowances are one-time use benefits; no remaining balance.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Services provided as a result of any Worker's Compensation law.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Plano lenses and non-prescription sunglasses (except for 20% discount).
- Services or materials provided by major medical coverage under any other group benefit providing for vision care.
- Two pair of glasses in lieu of bifocals.
- Aniseikonic lenses.
- Discounts do not apply for benefits provided by other group benefit plans.
- Lost or broken materials are not covered.



Flexible Spending Account Program Overview

Use your FSA to save 25% or more on the things you buy every day...

We all pay taxes. We all buy things like prescriptions, bandages, and glasses or contacts - not to mention co-pays, child care, and braces. And we all like to save money.

A Flexible Spending Account (FSA) uses pre-tax dollars to help you save on health care and dependent care expenses. Once the plan year begins, the money in your FSA is yours to spend immediately, on a wide range of needs for yourself and your family. And because this FSA from Flex Made Easy is so easy to use, there's no hassle, less waiting - and no reason to miss out on enrollment.



It's Covered

You probably know you can cover your co-pays, deductibles, dental and vision care, and prescriptions with your health care FSA. But did you know it's good for hundreds of over-the-counter items such as bandages and contact lenses solution, not to mention many services, too? You can also use it for Over-the-Counter drugs and medicines, as long as you get a prescription from your doctor.

Qualified medical expenses include:

- ✓ Co-pays, deductibles, co-insurance
- ✓ Dental expenses
- ✓ Eyeglasses, laser surgery, contact lenses
- ✓ Prescription drugs
- ✓ Over-the-counter supplies
- ✓ Chiropractic care

Qualified dependent care expenses include:

- ✓ Daycare
- ✓ Babysitting
- ✓ Before & after school care
- ✓ Pre-k
- ✓ Summer day camps
- ✓ Care for older dependents in need of assistance



Flexible Spending Account Program Overview

Everyday savings....

Saving is simple. When you enroll in the program, you set aside some of your pay before taxes to use on eligible expenses. The more you put in, the more you save on your tax bill.



It's easy...

It's your money. The program just helps you save it from taxes, and spend it on your health and your family. Flex Made Easy provides convenient payment and reimbursement options. Just swipe your FSA Debit Card to pay for eligible medical and/or dependent care expenses.

If you need to submit a claim, you can complete your transaction through our secure mobile application, our online portal, by email, fax or regular postal mail. Sign up for direct deposit, and get your funds back fast!!

Once you enroll, you will receive detailed instructions for accessing your account online through the Flex Made Easy secure online portal.



Contact



410 Archibald
Kansas City, MO 64111



1-855-615-3679



info@FlexMadeEasy.com



This worksheet will help you determine the dollar amount you will spend for medical expenses during the plan year. In order to maximize your savings, please include expenses for you, your spouse and any of your dependents in your calculation.

Medical Expenses not covered by Insurance

Annual Estimate

Deductibles, co-pays, coinsurance	\$ _____
Physician visits/routine exams	\$ _____
Prescription Drugs	\$ _____
Insulin/Syringes	\$ _____
Annual physicals	\$ _____
Chiropractic treatments	\$ _____
Other: _____	\$ _____

Subtotal Medical Expenses \$ _____

Dental Expenses not covered by Insurance

Checkups/cleanings	\$ _____
Fillings	\$ _____
Root Canals	\$ _____
Crowns/Bridges/Dentures	\$ _____
Oral Surgery	\$ _____
Orthodontia	\$ _____
Other: _____	\$ _____

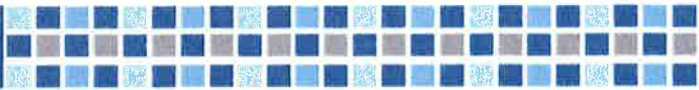
Subtotal Dental Expenses \$ _____

Vision/Hearing Expenses not covered by Insurance

Exams	\$ _____
Eyeglasses	\$ _____
Prescription Sunglasses	\$ _____
Contact Lenses & Cleaning Solutions	\$ _____
Corrective Eye Surgery (LASIK, cataract etc.)	\$ _____
Hearing exams/hearing aids & batteries	\$ _____

Subtotal Vision Expenses \$ _____

Total Medical Expenses \$ _____



Qualified Expenses

- ✓ Acupuncture
- ✓ Alcoholism treatment
- ✓ Ambulance
- ✓ Birth control pills
- ✓ Braille books and magazines
- ✓ Chiropractors
- ✓ Coinsurance amounts and deductibles
- ✓ Contact lenses, solutions and cleaners
- ✓ Crutches and wheelchairs
- ✓ Dental treatment*
- ✓ Dermatologist visits*
- ✓ Eyeglasses (prescription); vision exams
- ✓ Guide dog or other animal aide
- ✓ Hearing devices and batteries
- ✓ Hospital services
- ✓ Immunizations (including flu shots)
- ✓ Infertility treatments
- ✓ Insulin
- ✓ Laboratory/diagnostic fees
- ✓ Language training for child with disability
- ✓ Laser eye surgery
- ✓ Learning disability
- ✓ Massage therapy (medical necessity)*
- ✓ Norplant insertion or removal
- ✓ Nursing services
- ✓ Nutritionist's expenses (medical necessity)
- ✓ Occlusal guards to prevent teeth grinding
- ✓ Orthodontia
- ✓ Over-the-counter drugs (require a prescription)*
- ✓ Pap smears
- ✓ Physical therapy
- ✓ Prescription drugs
- ✓ Prosthetics
- ✓ Psychologist
- ✓ Reading glasses
- ✓ Smoking cessation programs
- ✓ Sterilization
- ✓ TMJ related treatments
- ✓ Transplants
- ✓ Travel expenses related to medical care only
- ✓ Wigs (medical reasons only)
- ✓ X-ray fees

Ineligible Expenses

- ✓ Burial expenses
- ✓ Cosmetic procedures (unless necessary to improve a deformity arising from congenital abnormality, personal injury from an accident or trauma, or a disfiguring disease)
- ✓ Dancing lessons
- ✓ Diapers or diaper service
- ✓ Ear piercing
- ✓ Electrolysis (see cosmetic procedures)
- ✓ Exercise equipment, unless prescribed for a specific medical condition
- ✓ Face lifts (see cosmetic procedures)
- ✓ Fitness programs for general health
- ✓ Funeral expenses
- ✓ Hair transplant (see cosmetic procedures)
- ✓ Health club dues
- ✓ Holistic or natural remedies
- ✓ Illegal operations and treatments
- ✓ Items paid or payable by insurance
- ✓ Items you intend to claim as a credit for income tax purposes
- ✓ Marriage counseling
- ✓ Maternity clothes
- ✓ Non-prescription sunglasses (sunclips)
- ✓ Nursing care for a normal, healthy baby
- ✓ Nutritional supplements (general good health)
- ✓ Overnight camp (Dependent Care)
- ✓ Premiums for group health coverage maintained through spouse's employer or individual insurance premiums
- ✓ Rogaine (see cosmetic procedures)
- ✓ Safety glasses (unless prescription)
- ✓ Swimming lessons
- ✓ Tanning salons and equipment
- ✓ Teeth whitening or bleaching (even if as a result of a congenital defect)
- ✓ Vision discount programs or warranty charges
- ✓ Vitamins (over-the-counter)
- ✓ Warranties for eyeglasses and/or hearing aids
- ✓ Weight loss programs and drugs (unless a medical necessity exists for a specific medical condition)

* Items are eligible for reimbursement through a Health Care FSA or an HRA if they are treating a current or imminent medical condition. Some items may require additional documentation such as a letter of medical necessity or a prescription (for over-the-counter medications) from your medical provider. Please visit www.FlexMadeEasy.com for more detailed information and a more comprehensive list of eligible expenses.

FLEXIBLE SPENDING ACCOUNTS

How do Flexible Spending Accounts Work?

Flexible Spending Accounts (FSAs) are like personal bank accounts. They allow you to set aside money for healthcare and/or dependent care expenses on a pre-tax basis. You can enroll in a Healthcare FSA and/or a Dependent Day Care FSA. Your election will cover you from your enrollment date through the end of the plan year unless you have a change in family status.

You can elect to have a portion of your salary withheld on a pre-tax basis for health or dependent care expenses you incur during the plan year. The funds will be placed into an account to be used during the year. If you contribute to both FSAs, you cannot use amounts contributed to one account to pay expenses eligible for payment from another account. For example, you cannot pay medical expenses from your Dependent Day Care FSA.

Health Care FSA

During annual enrollment you may elect to contribute monies into the Health Care FSA during the coming plan year. The amount you elect to set aside will be deducted from your paycheck in equal installments during the plan year. Please note that the maximum annual contribution to a Health Care FSA account \$2,550.

Eligible health care expenses include copayments, deductibles, coinsurance, certain orthodontic procedures and other health-related expenses incurred by you or a family member. In addition, over-the-counter medicines are eligible for reimbursement with a prescription.

Dependent Care FSA

You can contribute up to \$5,000 per household each year to the Dependent Day Care FSA to pay for dependent care expenses. The amount you elect to set aside will be deducted from your paycheck in equal installments during the coming year.

Eligible expenses are only those incurred for the care of a child under 13 years of age (or a disabled child older than age 13) who qualifies as your dependent for tax purposes; or, anyone you can claim as a dependent, such as an elderly parent or disabled spouse.

Use It Or Lose It

It is very important that you estimate accurately when determining how much to contribute to either FSA. FSAs can provide significant tax advantages for employees when the contributions are made on a pre-tax basis. For this reason the IRS requires that you use all of the money in your account(s) during the plan year. Any money remaining in your account(s) at the end of the plan year will be forfeited.

Limited Purpose FSA

If you are enrolled in a High Deductible Health Plan (HDHP) you may choose not to participate in the traditional FSA. In many circumstances it may benefit you to participate in a Limited Purpose FSA for unreimbursed vision and dental expenses.

Debit Card

Participating in the flex plan is even easier with a debit card. If you participate in the flex plan you will receive a debit card. It may be used at your pharmacy, the doctor's office or for mail-order prescriptions. You may be asked to substantiate a purchase, so make sure you keep your receipts. Upon request, simply fax your receipt to Kabel Business Services to confirm the purchase was for a qualified expense. Failure to do this may result in your card being suspended

VOLUNTARY TERM LIFE INSURANCE

GUARDIAN

Keystone Learning Services provides benefit eligible employees with the option to enroll in a term life insurance plan, as well as a life insurance benefit for spouses and/or child(ren). Purchasing term life insurance through Keystone Learning Services grants you lower rates, limited underwriting requirements (if any) and superior plan features. If you have a life event change, please remember to contact Human Resources to update your beneficiary information.

Plan Feature/Provision	Plan Design Details
Employee Benefit: <ul style="list-style-type: none"> - Plan Maximum - Guarantee Issue (Initial year only) - Incremental Purchase Amounts 	<ul style="list-style-type: none"> - \$500,000 - \$150,000 - \$10,000
Spouse Benefit: <ul style="list-style-type: none"> - Plan Maximum - Guarantee Issue (Initial year only) - Incremental Purchase Amounts 	<ul style="list-style-type: none"> - \$250,000 - \$25,000 - \$5,000
Child(ren) Benefit: <ul style="list-style-type: none"> - Plan Maximum - Guarantee Issue (Initial year only) - Incremental Purchase Amounts 	<ul style="list-style-type: none"> - \$10,000 - \$10,000 - \$10,000
Premiums	Increase on plan anniversary after you enter next five-year age band
Portability	Yes, with age restrictions
Conversion	Yes, with restrictions, see certificate
Accelerated Life Benefit	Yes
Waiver of Premium	For employees disabled prior to age 60; with premiums waived till age 65 if conditions met
Benefit Reductions	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Covered Participants Age (Spouse rate based on Employee Age)	Employee Monthly Rate per \$10,000	Spouse Monthly Rate per \$5,000
< 30	\$.54	\$.27
30 - 34	\$.67	\$.34
35 - 39	\$.90	\$.45
40 - 44	\$1.23	\$.62
45 - 49	\$1.94	\$.97
50 - 54	\$2.93	\$1.47
55 - 59	\$4.82	\$2.41
60 - 64	\$8.59	\$4.30
65 - 69	\$15.10	\$7.55

Child(ren) Monthly Rate per \$10,000	\$1.67
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SHORT TERM DISABILITY INSURANCE

Dearborn National

Keystone Learning Services provides full-time employees with the option to purchase one of four short term disability income benefit plan options. In the event you become disabled from an injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Short Term Disability Income Benefits

Plan Overview 1	
Benefits Begin	1st Day Following an Injury / 4 th Day Following a Sickness
Maximum Benefit Period	26 Weeks
Percentage of Income Replaced	\$100 - \$1,500 in increments of \$50 not to exceed 66.67% of weekly earnings
Exclusions	Benefit does not cover work-related accidents or injuries.
Pre-existing Condition Waiting Period	3/12

Age Band	Monthly Rates per \$50 Weekly Benefit
Composite Rates	\$4.88

Plan Overview 2	
Benefits Begin	8 th Day Following an Injury / 8 th Day Following a Sickness
Maximum Benefit Period	26 Weeks
Percentage of Income Replaced	\$100 - \$1,500 in increments of \$50 not to exceed 66.67% of weekly earnings
Exclusions	Benefit does not cover work-related accidents or injuries.
Pre-existing Condition Waiting Period	3/12

Age Band	Monthly Rates per \$50 Weekly Benefit
Composite Rates	\$3.68

Short Term Disability Income Benefits (continued)

Plan Overview 3	
Benefits Begin	15 th Day Following an Injury / 15 th Day Following a Sickness
Maximum Benefit Period	26 Weeks
Percentage of Income Replaced	\$100 - \$1,500 in increments of \$50 not to exceed 66.67% of weekly earnings
Exclusions	Benefit does not cover work-related accidents or injuries.
Pre-existing Condition Waiting Period	3/12

Age Band	Monthly Rates per \$50 Weekly Benefit
Composite Rates	\$2.90

Plan Overview 4	
Benefits Begin	31 st Day Following an Injury / 31 st Day Following a Sickness
Maximum Benefit Period	26 Weeks
Percentage of Income Replaced	\$100 - \$1,500 in increments of \$50 not to exceed 66.67% of weekly earnings
Exclusions	Benefit does not cover work-related accidents or injuries.
Pre-existing Condition Waiting Period	3/12

Age Band	Monthly Rates per \$50 Weekly Benefit
Composite Rates	\$2.25



Why do I need Cancer Insurance?

Because cancer hits people everyday....



men will be struck with cancer



women will be struck with cancer

Source: American Cancer Society

But isn't that why I have medical insurance?



of all cancer costs are

66%

non-medical

and insurance won't cover things like:

- ✓ Child care
- ✓ Transportation
- ✓ Loss of Wages
- ✓ Living expenses
- ✓ Specialists

- ✓ Meals
- ✓ Lodging
- ✓ Special Diets
- ✓ Experimental treatments

BenefitsDirect helps you plan for the unexpected!

Our Cancer/Specified Disease Plan pays TAX FREE benefits directly to you so that you can focus on getting well, rather than being distracted by the cost of medical and personal bills.

Monthly Rates

Individual

Single Parent

Family

Base Cancer/Specified Diseases
Intensive Care Rider
Optional 1st Occurrence Rider
(\$5,000 Benefit)
(\$3,000 Benefit)

\$19.67
2.70
\$5.48
\$3.29

\$24.29
3.83
\$5.98
\$3.59

\$33.48
5.38
\$8.38
\$5.03

CANCER PACKAGE

(includes \$5K for FOB & ICU RIDERS)

\$27.94

\$34.10

\$47.14

The Cancer/Specified Disease Plan gives you another benefit...

peace of mind...

A New Dimension in Supplemental Cancer Insurance

Underwritten by:

Loyal American
Life Insurance Company®

Administrative Office: P.O. Box 1604
Duncan, OK 73534

Toll Free: 1-800-366-8354

A.M. Best - Loyal American Life Insurance Company® holds an **A (Excellent)** rating from this widely recognized independent insurance industry analyst on the basis of financial position and operating performance.

A Promise

In an era where many financial services companies are concerned with bottom-line results at the expense of customer service and loyalty, we come from the old school. We take great pride in providing the finest services to our employer groups, policyholders, business associates, agents - to everyone with whom we come in contact.

BASE POLICY BENEFITS

No Lifetime Maximum for Majority of Benefits

BENEFIT PROVISIONS. We will pay the benefits described in the policy for the treatment of an Insured Person's Cancer, provided he or she is covered under an issued policy which remains in force. Payment will be made in accordance with all applicable policy provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. For policies issued on a payroll deduction basis, benefits are payable for a positive diagnosis that begins after the Effective Date. The positive diagnosis must be for Cancer as defined in the policy.

- 1. POSITIVE DIAGNOSIS BENEFIT.** We will pay the expense incurred but not to exceed **\$300 per Calendar Year** for one test that confirms the Positive Diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.
- 2. NATIONAL CANCER INSTITUTE DESIGNATED COMPREHENSIVE CANCER TREATMENT CENTER EVALUATION/CONSULTATION BENEFIT** We will pay the expense incurred, but not to exceed a **lifetime maximum of \$750**, if an Insured Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred but not to exceed a **lifetime maximum of \$350**. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. **This benefit is payable one time during the lifetime of the Insured Person.**
- 3. SECOND AND THIRD SURGICAL OPINION EXPENSE BENEFIT** We will pay the **expense incurred** for a written second surgical opinion concerning the recommendation of Cancer surgery and if the second surgical opinion is in conflict with that of the Physician originally recommending the surgery and the Insured Person desires a third opinion, We will pay the expense incurred for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.
- 4. MEDICAL IMAGING, TREATMENT PLANNING AND MONITORING EXPENSE BENEFIT** We will pay the expense incurred, but not to exceed **\$1,000 per Calendar Year**, for laboratory tests, diagnostic X-rays, medical images, when used in Cancer treatment plans related to Radiation Treatment, Chemotherapy or Immunotherapy.
- 5. ANTI-NAUSEA MEDICATION EXPENSE BENEFIT** We will pay the expense incurred for anti-nausea medication, but not to exceed **\$150 per Calendar Month**, when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.
- 6. COLONY STIMULATING FACTOR OR IMMUNOGLOBULIN EXPENSE BENEFIT** We will pay the expense incurred but not to exceed **\$1,000 per Calendar Month** for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.
- 7. OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER EXPENSE BENEFIT** We will pay the **expense incurred** from an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities for the performance of a surgical procedure covered under this Policy but not to exceed **\$350 per day**.
- 8. PROSTHESIS EXPENSE BENEFIT**
 - (A.) Surgically Implanted Breast Prosthesis** We will pay the **expense incurred** for a surgically implanted prosthetic device required and prescribed to restore normal body contour lost as the direct result of an Insured Person's breast removal for the treatment of Cancer. The Surgically Implanted Breast Prosthesis Benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider.
 - (B.) Non-Surgically Implanted Prosthesis** We will pay the expense incurred **not to exceed \$2,000 per amputation** for an artificial limb or other non-surgically implanted prosthetic device that is prescribed and required to restore normal body function lost as the direct result of an Insured Person's amputation for the treatment of Cancer. **We will pay a lifetime maximum of \$2,000 per amputation.** The cost of replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.
- 9. NON-LOCAL TRANSPORTATION EXPENSE BENEFIT** We will pay the **expense incurred, but not to exceed the coach fare on a Common Carrier for the Insured Person and one adult companion's travel** to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private **vehicle mileage allowance of \$.50 per mile** for Non-Local transportation in lieu of the common carrier coach fare.

- 10. LODGING EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$75 per day** for a room in a motel, hotel or other appropriate lodging facility (other than a private residence), when an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center. The room must be occupied by the Insured Person or an adult companion which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. **This benefit is limited to 100 days per Calendar Year.**
- 11. INPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Inpatient.
- 12. OUTPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay **the expense incurred not to exceed \$300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Outpatient.
- 13. BONE MARROW DONOR EXPENSE BENEFIT** *We will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule* for each day a live donor, other than the Insured Person, is confined in a Hospital for the harvesting of bone marrow or stem cells used in a bone marrow or stem cell transplant for the treatment of an Insured Person's Cancer.
- 14. BONE MARROW OR STEM CELL TRANSPLANT EXPENSE BENEFIT** We will pay the expense incurred not to exceed a **lifetime maximum of \$15,000 for surgical and anesthesia procedures** (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Cancer. This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to an issued policy.
- 15. AMBULANCE EXPENSE BENEFIT** We will pay the **expense incurred** for ambulance service if an Insured Person is transported to a Hospital where he or she is admitted as an inpatient for the treatment of Cancer. The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.
- 16. INPATIENT OXYGEN EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$300 per Hospital confinement** for oxygen prescribed by a Physician and received by an Insured Person while confined in a Hospital for the treatment of Cancer.
- 17. ATTENDING PHYSICIAN EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$40 per day** for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person and the amount stated is the maximum amount that will be payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.
- 18. INPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$150 per day** for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital and the Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.
- 19. OUTPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$150 per day** limited to the same number of days of the prior Hospital confinement for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family. Charges must begin following a period of Hospital confinement for which benefits are payable under this Policy.
- 20. CONVALESCENT CARE FACILITY EXPENSE BENEFIT** We will pay the expense incurred **not to exceed \$100 per day** for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to a Convalescent Care Facility. The Convalescent Care Facility Confinement must: be due to Cancer; begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer; be authorized by a Physician as being medically necessary for the treatment of Cancer.
- 21. RENTAL OR PURCHASE OF MEDICAL EQUIPMENT EXPENSE BENEFIT** We will pay the **lesser of the expense incurred** not to exceed **\$1,500 per Calendar Year** for either the rental or purchase of covered medical equipment designed for home use, required and ordered by the Insured Person's attending Physician as the direct result of the treatment of Cancer. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

- 22. HOME HEALTH CARE EXPENSE BENEFIT** We will pay benefits for the following Covered Charges when a Insured Person requires Home Health Care for the treatment of Cancer.
- 1. Home Health Care Visits** - We will pay the expense incurred for Home Health Care Visits **not to exceed \$75 for each day** on which one or more such visits occur. We will not pay this benefit for more than **60 days** in any Calendar Year.
 - 2. Medicine and Supplies** - We will pay the expense incurred **not to exceed \$450 in any Calendar Year** for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
 - 3. Services of a Nutritionist** - We will pay the expense incurred **not to exceed a lifetime maximum of \$300** for the services of a nutritionist to set up programs for special dietary needs.
- 23. HOSPICE CARE EXPENSE BENEFIT** We will pay the expense incurred for Hospice Care **not to exceed \$100 per day**, when such care is required because of Cancer. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis as being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. **The lifetime maximum benefit is 365 days of Hospice Care**
- 24. HAIRPIECE EXPENSE BENEFIT** We will pay the expense incurred not to exceed **a lifetime maximum of \$150** for the purchase of a wig or hairpiece that is required as the direct result of hair loss due to Cancer treatment.
- 25. PHYSICAL, SPEECH, AUDIO THERAPY AND PSYCHOTHERAPY EXPENSE BENEFIT**
We will pay the expense incurred **not to exceed \$25 per therapy session** for:
1. Physical therapy treatments given by a license Physical Therapist, or
 2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
 3. Audio therapy given by a licensed Audiologist; or
 4. Psychotherapy given by a licensed Psychologist.
- These sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. **Benefits may not exceed \$1,000 per Calendar Year.**
- 26. WAIVER OF PREMIUM.** We will waive the premiums starting on the first premium due date **following a 60 day period of Total Disability** of the Named Insured due to Cancer. The Named Insured must: (a) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (b) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled.
-

GUARANTEED RENEWABLE FOR LIFE. Except for fraud or material misrepresentation, the Named Insured has the right to renew this Policy as long as premiums are paid on time.

PREMIUMS SUBJECT TO CHANGE. On any premium due date after the first Policy Anniversary, We may change the premium rates for this policy only if We also change the rates for all other policies issued in the same Rating Class. No change in the premiums will be made because of the number of claims an Insured Person files nor because of a change in an Insured Person's health.

EXCLUSIONS AND LIMITATIONS. No benefits will be paid under the Policy or any attached riders for: 1. any loss due to any disease or illness other than Cancer, or a listed covered Specified Disease; 2. care and treatment received outside the territorial limits of the United States; 3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined; 4. treatment that has not been approved by a Physician as being medically necessary; or 5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

PRE-EXISTING CONDITIONS LIMITATION. We will not pay benefits for expenses resulting from Pre-existing Conditions during the first two years (in SD for the first 12 months, in TX for the first 6 months if the age at issue is over 64 years) after coverage becomes effective.

"Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years (in SD within one year, in WV within two years) prior to the effective date of coverage for each Insured Person.

In MS "Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, for which diagnosis, advice or treatment is given or for which signs or symptoms cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately preceding the effective date of coverage.

THIS IS A CANCER ONLY POLICY, which should be used to supplement your existing health care protection.

Insurance coverage is provided by form number series L-6040 and associated riders. This advertisement highlights some features of the policy and riders, but is not the insurance contract. An issued policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. Please read the policy and riders for detailed coverage information.

ADDITIONAL BENEFITS INCLUDED	PLAN MAXIMUM
<p>ANNUAL CANCER SCREENING BENEFIT RIDER (form L-6041)</p> <p>A. Basic Benefit We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Policy Schedule, once per calendar year per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to: mammogram, pap smear, breast ultrasound, ThinPrep, biopsy, chest x-ray, thermography, colonoscopy, flexible sigmoidoscopy, hemocult stool specimen, PSA (blood test for prostate cancer), CEA (blood tests for colon cancer), CA125 (blood test for ovarian cancer), CA15-3 (blood test for breast cancer), serum protein electrophoresis (blood test for myeloma).</p> <p>B. Additional Benefit We will pay the expense incurred, but not to exceed two times the maximum benefit amount per calendar year as shown on the Policy Schedule, for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above for an Insured Person. This additional benefit is payable regardless of the results of the additional diagnostic procedure. However, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained in the base Policy.</p>	<p>\$50 Per Calendar Year</p> <p>\$100 Per Calendar Year</p>
<p>ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT BENEFIT RIDER (form L-6045)</p> <p>We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Policy Schedule, per calendar year per Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment must be for the treatment of an Insured Person's Cancer. The benefit amount shown on the Policy Schedule is the maximum calendar year benefit available per Insured Person regardless of the number or types of Cancer treatments received in the same year.</p>	<p>\$10,000 Per Calendar Year</p>
<p>SURGICAL BENEFIT RIDER (form L-6048)</p> <p>Surgical Expense We will pay the Surgical Expense benefit for a surgical procedure for the treatment of an Insured Person's Cancer (except Skin Cancer) according to the Surgical Schedule shown in this rider. However, in no event will the amount payable exceed the maximum Surgical Expense benefit shown on the Policy Schedule, nor will it exceed the expense incurred.</p> <p>Anesthesia Expense We will pay the anesthesia expense incurred, not to exceed 25% of the covered Surgical Expense benefit for the operation performed. This includes the services of an anesthesiologist or of an anesthetist under supervision of a physician for the purpose of administering anesthesia.</p> <p>Breast Reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site, with microvascular anastomosis (supercharging) is one of the surgical procedures listed in the Surgical Schedule. If this procedure is performed on an Insured Person as the result of a mastectomy for which We paid a Surgical Expense benefit for the treatment of Breast Cancer, We will pay the expense incurred not to exceed \$900 per \$1,000 of the Surgical Benefit issued.</p> <p>Skin Cancer Surgery Expense We will pay the expense incurred, not to exceed the procedure amount listed in this rider (\$125 to \$750 depending on the procedure) when a surgical operation is performed on an Insured Person for treatment of a diagnosed Skin Cancer. This benefit is payable in lieu of any benefits for Surgical Expense and Anesthesia Expense which are not applicable to Skin Cancer.</p>	<p>\$4,000 Procedure Maximum</p> <p>\$1,000 Procedure Maximum</p> <p>\$3,600 Procedure Maximum</p> <p>Per Procedure</p>
<p>DAILY HOSPITAL CONFINEMENT BENEFIT RIDER (form L-6042)</p> <p>Confinements of 30 Days or Less We will pay the Daily Hospital Confinement benefit amount shown on the Policy Schedule for each of the first 30 days in each period of hospital confinement during which an Insured Person is confined to a hospital, including a government or charity hospital, for the treatment of Cancer.</p> <p>Confinements of 31 Days or More If an Insured Person is continuously confined to a hospital, including a government or charity hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement benefit amount shown on the Policy Schedule. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital.</p> <p>Benefits for an Insured Dependent Child under Age 21 The amount payable under this benefit will be double the Daily Hospital Confinement benefit shown on the Policy Schedule if the Insured Person so confined is a dependent child under the age of 21.</p>	<p>\$150 Per Day</p> <p>\$300 Per Day</p> <p>\$300/ \$600 Per Day</p>
<p>SPECIFIED DISEASE BENEFIT RIDER (form L-6052)</p> <p>If an Insured Person is first diagnosed with one or more covered Specified Diseases and is hospitalized for the definitive treatment of any covered Specified Disease, We will pay benefits according to the provisions of this rider.</p> <p>COVERS THESE 38 SPECIFIED DISEASES</p> <p>Addison's Disease, Amyotrophic Lateral Sclerosis, Botulism, Bovine Spongiform Encephalopathy, Budd-Chiari Syndrome, Cystic Fibrosis, Diptheria, Encephalitis, Epilepsy, Hansen's Disease, Histoplasmosis, Legionnaire's Disease, Lyme Disease, Lubus Erythematousus, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Neimann-Pick Disease, Osteomyelitis, Poliomyelitis, Q Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickel Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Tuberculosis, Tularemia, Typhoid Fever, Undulant Fever, West Nile Virus, Whipple's Disease, Whooping Cough.</p> <p>BENEFITS</p> <p>Initial Hospitalization Benefit We will pay a benefit of \$1,500 per unit of coverage selected when an Insured Person is confined to a hospital (for 12 or more hours, not applicable in SD) as a result of receiving treatment for a Specified Disease. This benefit is payable only once per period of confinement and once per calendar year for each Insured Person.</p> <p>Hospital Confinement Benefit We will pay a benefit of \$300 per day per unit of coverage selected when an Insured Person is hospitalized during any continuous period of 30 days or less for the treatment of a covered Specified Disease. Benefits will double per day beginning with the 31st day of continuous confinement.</p> <p>If the hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different Specified Disease, or unless the confinements are separated by 30 days or more.</p>	

ADDITIONAL BENEFIT AMOUNTS YOU MAY SELECT FOR ADDITIONAL PREMIUM

FIRST OCCURRENCE BENEFIT RIDER (form L-6043)

If an Insured Person receives a positive diagnosis of Internal Cancer, We will pay the First Occurrence benefit amount shown on the Policy Schedule.

\$5,000/\$3,000

Per Lifetime

If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, we will pay one and one-half times the First Occurrence benefit amount shown on the Policy Schedule.

\$7,500/\$4,500

Once Per Lifetime

HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER (form LG-6047)

Intensive Care Unit Benefit We will pay the daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule for an Insured Person's confinement in an ICU for sickness or injury.

\$600

Per Day

Double Intensive Care Unit Benefit We will pay double the daily Hospital Intensive Care Unit benefit amount shown on the Policy for an Insured Person's confinement in an ICU as a result of Cancer. We will also double this ICU benefit for only the initial ICU confinement resulting from an Insured Person's travel related injury, provided that the ICU confinement begins within 24 hours of the accident causing the travel related injury. A travel related injury includes being struck by an automobile, bus, truck, van, motorcycle, train or airplane; or being involved in an accident where the Insured Person was the operator or passenger in or on such vehicle.

\$1,200

Per Day

Step Down Unit Benefit We will pay one-half of the daily Hospital Intensive Care Unit benefit amount shown on the Policy Schedule for an Insured Person's confinement in a Step Down Unit for a sickness or injury.

\$300

Per Day

Additional Limitations and Exclusions for the Hospital Intensive Care Unit Benefit Rider If the rider is issued and coverage is in force, it will provide benefits if an Insured Person goes into a hospital Intensive Care Unit (including a Cardiac Intensive Care Unit or Neonatal Intensive Care Unit). Benefits start the first day of confinement in an ICU for sickness or injury. Any combination of benefits payable under this rider is limited to a maximum of 45 days per each period of confinement.

ALL BENEFITS CONTAINED IN THIS HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER REDUCE BY ONE-HALF AT AGE 75.

Benefits are not payable for any ICU or Step Down Unit confinement that results from intentional self-inflicted injury; or the Insured Person's being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on and according to the advice of a medical practitioner.

This page is an Insert to be used **ONLY** with Brochure Form L-6040. If you do not have this Brochure, ask that your agent provide one for you. All exclusions, limitations, definitions and terms of renewability of the Limited Benefit Cancer Expense Policy (form L-6040) apply to these riders. **THESE ARE LIMITED RIDERS**

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Life can take a tumble.

With a full-time job and three active kids, Marsha has a lot of demands on her time — and her pocketbook. So if her kids break something other than a window, she doesn't want an injury to break her bank account as well.



Benefits that pay for covered accidents while you are on the road to recovery

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- cuts repaired by stitches
- coma due to a covered injury
- eye injuries
- ruptured discs
- concussion

Some covered expenses include:

- emergency room treatment
- outpatient surgery facility
- doctor's office visit
- hospitalization
- occupational therapy
- speech therapy
- chiropractic visit
- physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Who's at risk?

- Every 10 minutes, over 700 Americans suffer an injury severe enough to seek medical help.¹
- About two-thirds of disabling injuries suffered by American workers are not work-related, and therefore not covered by workers' compensation.²

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at home
Injury: Broken toe and ACL tear (knee ligament injury)

Out-of-pocket expenses incurred:

\$100 emergency room copay
\$500 deductible
\$750 copay for surgery (\$3,750 x 20%)
\$150 copay for 10 physical therapy visits

Total out-of-pocket expenses: \$1,500

Benefits paid:

\$150 emergency room visit
\$100 appliance (knee brace)
\$150 fractured toe
\$800 surgical ligament tear repair
\$ 75 follow-up appointment
\$150 for six physical therapy sessions

Total benefit paid under policy: \$1,425

*Costs of treatment and benefit amounts may vary. Example is based on the level 2 schedule of benefits.

How to apply) To learn more, watch for information from your employer.

Be sure to review this schedule of benefits.

It shows the many ways this coverage can pay a benefit if you are injured.

Covered injuries	Benefit amount	Emergency and hospitalization benefits	Benefit amount
Fractures		Ambulance (ground, once per accident)¹	\$400
Open	Up to \$7,500	Air ambulance	\$1,500
Closed	Up to \$3,750	Emergency room treatment	\$150
Chips	25% of closed amount	Emergency treatment in physician office/urgent care facility	\$75
Dislocations		Hospital admission (admission or intensive care admission once per covered accident)	\$1,000
Open	Up to \$6,000	Intensive care admission (same as above)	\$1,500
Closed	Up to \$3,000	Hospital confinement (per day up to 365 days)	\$200
Burns		Intensive care confinement (per day up to 15 days)	\$400
At least 10 square inches, but less than 20 square inches	2nd degree – \$0 3rd degree – \$2,500	Medical imaging test (once per accident)	\$200
At least 20 square inches, but less than 35 square inches	2nd degree – \$0 3rd degree – \$5,000	Outpatient surgery facility service (once per accident)	\$300
35 or more square inches of the body surface	2nd degree – \$1,000 3rd degree – \$10,000	Pain management (epidural, once per accident)	\$100
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit		
Skin graft for any other accidental traumatic loss of skin			
At least 10 square inches, but less than 20 square inches	\$150		
At least 20 square inches, but less than 35 square inches	\$250		
35 or more square inches of the body surface	\$500		
Concussion	\$150		
Coma	\$10,000		
Ruptured disc	\$800		
Knee cartilage			
Torn	\$750		
Exploratory	\$150		
Laceration	\$25 – \$600		
Tendon/ligament and rotator cuff			
Repair of one	\$800		
Repair of two or more	\$1,200		
Exploratory only	\$150		
Dental work, emergency			
Extraction	\$100		
Crown	\$300		
Eye injury	\$300		

*Check it out!
See how much this plan
pays for actual injuries
and treatment.*

Treatment and other services	Benefit amount
Surgery benefit	
Open abdominal, thoracic	\$1,500
Exploratory (without repair)	\$150
Hernia repair	\$150
Physician follow-up visit (2 visits per accident)	\$75
Chiropractic visit (up to 3 visits per calendar year) ²	\$25
Therapy services (up to 10 per accident)	
Occupational therapy	\$25
Speech therapy	\$25
Physical therapy	\$25
Prosthetic device or artificial limb	
One	\$750
More than one	\$1,500
Appliance (once per accident)	\$100
Blood, plasma and platelets	\$400
Travel due to accident Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip ³	\$0.40 per mile
Lodging (per night up to 30 days per accident) ⁴	\$150
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	\$100

Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	\$50,000
Spouse	\$20,000
Child	\$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee – \$150,000; spouse – \$60,000; child – \$30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	\$15,000
Loss of one hand and one foot; or	\$15,000
Loss of one hand or one foot;	\$7,500
Loss of two or more fingers, toes or any combination; or	\$1,500
Loss of one finger or toe	\$750
Catastrophic accidental dismemberment† — once per lifetime, not payable with catastrophic loss⁵	
Loss of both hands or both feet; or loss of one hand and one foot	
Employee (prior to age 65)	\$100,000
– Spouse and child	\$50,000
Employee (ages 65–69)	\$50,000
– Spouse and child	\$25,000
Employee (70+ years old)	\$25,000
– Spouse and child	\$12,500
Accidental loss — paralysis, sight, hearing and speech⁶	
Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	\$15,000
Loss of sight of both eyes; or	\$15,000
Loss of sight of one eye; or	\$7,500
Loss of the hearing of one ear	\$7,500
Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment	
Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Employee (prior to age 65)	\$100,000
– Spouse and child	\$50,000
Employee (ages 65–69)	\$50,000
– Spouse and child	\$25,000
Employee (70+ years old)	\$25,000
– Spouse and child	\$12,500

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Finally, benefits made simple



THIS IS A LIMITED POLICY.

For NH and NY, please refer to the state specific form for benefit variations.
In CT, there is a \$500 benefit payable for outpatient emergency room medical care for accidental ingestion of a controlled substance.

† Catastrophic accidental benefit — payable after fulfilling a 365 day elimination period.

1 In CA and CT, no ground or air ambulance benefit is payable.

2 In KS, no chiropractic benefit is payable.

3 In NJ, no transportation benefit is payable.

4 In NJ, no lodging benefit is payable.

5 In ME, catastrophic benefits amounts vary. In PA, no catastrophic accidental dismemberment benefit is payable.

6 In PA, no paralysis benefit is payable.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

The information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

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Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur on and off the job. Accident insurance is offered to all eligible employees who are actively at work. You decide if it's right for you and your family.

The following benefit is automatically included in your plan:

Catastrophic Benefit

This pays an additional sum if a covered individual has a serious injury — such as loss of sight, hearing or a limb — before age 65.

Four reasons to buy this coverage at work:

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are conveniently deducted from your paycheck.

Additional coverage options

Sickness Hospital Confinement Benefit

Depending on your plan, your employer may have chosen to include this benefit — or you may have the option to select it. This option pays the insured employee, spouse or children a daily benefit if he or she is in the hospital for a covered illness. Based on the plan your employer selects, the amount you receive can be \$100, \$200 or \$300 per day. Children's coverage pays 75% of the employee amount.

This benefit is available to family members who are covered by the base plan. There is an additional charge for this feature.

The benefit includes a 12-month pre-existing condition limitation and may vary by state. Employees and their spouses need to answer certain health questions when applying for this benefit.

Available family coverage

Who can have it?

Spouse coverage	Ages 17 to 64
Child coverage	Dependent children newborn until their 26th birthday, regardless of marital or student status. ³

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

My accident coverage

Coverage plan chosen: _____

Cost per pay period: \$ _____

Date deductions begin: ____/____/____

(For your records — complete during your enrollment)

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Finally, benefits made simple



THIS IS A LIMITED POLICY.

The base policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE — THE BASE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

ME — employees must be covered by comprehensive health insurance before applying for group accident insurance.

MN and NY — employees must be enrolled in a qualified major medical health plan before applying for accident insurance.

CO, CT, DC, KS, MN, NH, NJ and NY — the Sickness Hospital Confinement Benefit is not available.

¹ National Safety Council, *Injury Facts* (2012).

² National Safety Council, *Injury Facts* (2011).

³ In GA, IL and ND, child coverage is available newborn until their 27th birthday.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine
In NY, underwritten by: First Unum Life Insurance Company, New York, New York

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

Unum complies with all state civil union and domestic partner laws when applicable.

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Group Accident Rates and Disclosures (KS) ESSDACK

Monthly Premium			
Employee	Employee and Spouse	Employee and Child	Employee, Spouse and Child
\$15.04	\$24.32	\$28.08	\$37.36

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- participating or attempting to participate in a felony, and/or receiving injuries while being engaged in an illegal occupation or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the exclusions listed above, Unum will also not pay the catastrophic accidental dismemberment or catastrophic accidental loss benefit for the following injuries that are caused by or are the result of:

- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or
- last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy. Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE</p> <p>THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
--

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Could your bank account survive a serious illness?

Get protected with group Critical Illness insurance from Unum.

Lisa's story

Lisa was planning her daughter's wedding when a stroke disrupted her plans. Thanks to her Critical Illness coverage, Lisa was able to afford the treatment her medical insurance didn't cover. So she was able to focus on her goal for recovery: to dance at her daughter's wedding.



Who's at risk?

- The odds of developing cancer during a lifetime are one in two for men and one in three for women.¹
- Every 34 seconds someone in America will have a coronary event.²

Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions.

How to apply

To learn more, watch for information from your employer.

Three reasons to buy this coverage at work

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

How can Critical Illness insurance help?

Critical Illness insurance can pay a lump sum benefit at the diagnosis of a critical illness. \$5,000 to \$50,000 in \$1,000 increments — and you can use the money any way you see fit.

Covered conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	
Covered conditions with time limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident

Please see policy definitions for complete details about these covered conditions.

Group Critical Illness insurance

The following benefit is automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay \$50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Chest X-rays
- Stress tests
- Mammograms
- Colonoscopies

A full list of covered tests will be provided in your certificate.

Available family coverage

Who can have it?	Benefit
Employees who are actively at work	\$5,000 to \$50,000 in \$1,000 increments
Dependent children newborn until their 26th birthday, regardless of marital or student status All eligible children are automatically covered at 25% of the employee benefit amount (no additional cost)	Eligible children are covered for the same conditions as employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
Spouse ages 17 through 64 with purchase of employee coverage ⁴	From \$5,000 to \$30,000 in \$1,000 increments

Employees must be a U.S. citizen or legally authorized to work in the United States and actively at work at a U.S. location to receive coverage. Spouses and dependents must reside in the United States to receive coverage.

Provision

Reduction of benefits

The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary date after the insured individual's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

My Critical Illness coverage

Amount I applied for: \$ _____

Cost per pay period: \$ _____

Date deductions begin: ____/____/____

(For your records — complete during your enrollment)

THIS INSURANCE PROVIDES LIMITED BENEFITS.

1 American Cancer Society, "Cancer Facts & Figures 2015" (2015).
2 American Heart Association, "Heart Disease and Stroke Statistics — 2013 Update: A Report from the American Heart Association," Circulation (Jan. 1/8, 2013).
4 Spouses who work for the same employer can only be covered as either an employee or spouse, but not both.

Group Critical Illness Monthly Premiums:											
Employee / Issue Age (rates stay the same as day issued) / Non-Tobacco											
Benefit Amount	<25	25-29	30-34	35-39	40-44	45-49	50—54	55-59	60-64	65-69	70+
10,000	3.50	3.50	4.50	5.90	8.40	11.00	14.30	18.70	24.10	28.40	54.70
20,000	7.00	7.00	9.00	11.80	16.80	22.00	28.60	37.40	48.20	56.80	109.40
30,000	10.50	10.50	13.50	17.70	25.20	33.00	42.90	56.10	72.30	85.20	164.10
40,000	14.00	14.00	18.00	23.60	33.60	44.00	57.20	74.80	96.40	113.60	218.80
50,000	17.50	17.50	22.50	29.50	42.00	55.00	71.50	93.50	120.50	142.00	273.50

Group Critical Illness Monthly Premiums:											
Employee / Issue Age (rates stay the same as day issued) / Tobacco											
Benefit Amount	<25	25-29	30-34	35-39	40-44	45-49	50—54	55-59	60-64	65-69	70+
10,000	5.20	5.80	8.20	11.60	17.10	22.80	29.00	36.00	44.80	47.40	82.70
20,000	10.40	11.60	16.40	23.20	34.20	45.60	58.00	72.00	89.60	94.80	165.40
30,000	15.60	17.40	24.60	34.80	51.30	68.40	87.00	108.00	134.40	142.20	248.10
40,000	20.80	23.20	32.80	46.40	68.40	91.20	116.00	144.00	179.20	189.60	330.80
50,000	26.00	29.00	41.00	58.00	85.50	114.00	145.00	180.00	224.00	237.00	413.50

Group Critical Illness Monthly Premiums:											
Spouse / Issue Age (rates stay the same as day issued) / Non-Tobacco											
Benefit Amount	<25	25-29	30-34	35-39	40-44	45-49	50—54	55-59	60-64	65-69	70+
5,000	1.75	1.75	2.25	2.95	4.20	5.50	7.15	9.35	12.05	14.20	27.35
10,000	3.50	3.50	4.50	5.90	8.40	11.00	14.30	18.70	24.10	28.40	54.70
15,000	5.25	5.25	6.75	8.85	12.60	16.50	21.45	28.05	36.15	42.60	82.05
20,000	7.00	7.00	9.00	11.80	16.80	22.00	28.60	37.40	48.20	56.80	109.40
25,000	8.75	8.75	11.25	14.75	21.00	27.50	35.75	46.75	60.25	71.00	136.75

Group Critical Illness Monthly Premiums:											
Spouse / Issue Age (rates stay the same as day issued) / Tobacco											
Benefit Amount	<25	25-29	30-34	35-39	40-44	45-49	50—54	55-59	60-64	65-69	70+
5,000	2.60	2.90	4.10	5.80	8.55	11.40	14.50	18.00	22.40	23.70	41.35
10,000	5.20	5.80	8.20	11.60	17.10	22.80	29.00	36.00	44.80	47.40	82.70
15,000	7.80	8.70	12.30	17.40	25.65	34.20	43.50	54.00	67.20	71.10	124.05
20,000	10.40	11.60	16.40	23.20	34.20	45.60	58.00	72.00	89.60	94.80	165.40
25,000	13.00	14.50	20.50	29.00	42.75	57.00	72.50	90.00	112.00	118.50	206.75

Guarantee Issue:

Employee: \$10,000
Spouse: \$5,000
Child(ren): 25% of Employee Benefit

Wellness Premium:

Employee and Children: \$1.60
Family: \$3.20

Wellness is automatically included in the plan; if you elect Employee and Children or Family Coverage please add the above Wellness rate to your rate in the table above for total monthly rate.

BenefitsDirect

Customized Employee Benefit Programs

Lifetime Life Insurance & Long-Term Care

This is the **CHEAPEST** and **EASIEST** WAY TO BUY **LTC COVERAGE!**

Life Insurance w/ Guaranteed Rates to age 120

- Guaranteed Life Insurance rates to age 120, portable and individually-owned!
Other Group Life coverage decreases with age and premiums increase.

Long-Term Care Protection to Age 120

- Pays 4% of Face Amount paid monthly for up to 75 months (6+ yrs)!

Accelerated Death Benefit for Terminal Illness

- Automatically included, 50% of face amount advanced if
diagnosed with Terminal Illness!

Future Purchase Option

- Protects future insurability, opportunity to increase coverage on annual basis,
even as health status changes!

Limited Underwriting (Initial Eligibility Period Only) (Subject to Underwriting)

Employee coverage

- Up to \$75,000 for employees, NO HEALTH QUESTIONS
- Up to \$150,000 for employees, 4 HEALTH QUESTIONS

Spouse coverage

- Up to \$75,000 for spouses, 3 HEALTH QUESTIONS

Child(ren) coverage

- Child's Term Rider benefit—covers all dependent children in family (18 and
under on issue date, can remain on until age 23). NO HEALTH QUESTIONS
 - \$25,000 Term Policy can be converted to \$125,000 Term Policy at age 23

Underwritten by **Combined Insurance**
A Rating from A.M. Best

LifeTime Benefit Term – *Permanent Term Insurance that lasts a Lifetime!*

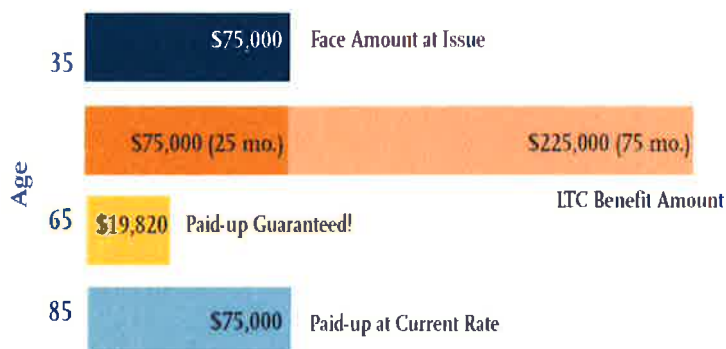
...Finally, a benefit solution for “Pre” and “Post” Retirement needs

Plan Features

- Life Insurance Premiums **Guaranteed** for Life
- Long Term Care coverage worth 3x your death benefit amount. That’s up to 75 Months of care for Nursing Home, Assisted Living and Home Care!
- Guaranteed acceptance up to **\$75,000**
- Paid-Up Insurance **starting in Tenth Year**
- Death Benefit is **Fully Paid-Up** prior to Age 100 on a current assumption basis
- Plan is **Portable** with no increase in life insurance premium
- Spouse and Children coverage available
- Accelerated Death Benefit for Terminal Illness included
- Guaranteed protection for Today and Tomorrow
- Sample rates provided on the following pages

An Example of How LifeTime Benefit Term with LTC Works

- A 35-year-old non-smoker can purchase \$75,000 of coverage including the Accelerated Death Benefit for Long Term Care and Terminal Illness with Extension of Long Term Care Benefits for \$10.92 weekly.
- At age 65, the employee would have guaranteed paid-up insurance of \$19,820.
- At age 85, the full face amount of \$75,000 would be paid-up based on current interest rates.
- Long Term Care benefit of \$3,000 (4% of \$75,000) per month would be available for up to 75 months.



MONTHLY NON-SMOKER RATES

Issue Age	\$25,000	\$50,000	\$75,000	\$100,000
19	N/A	22.50	33.75	45.00
20	N/A	23.04	34.56	46.08
21	N/A	23.46	35.19	46.91
22	N/A	23.92	35.87	47.83
23	N/A	24.29	36.44	48.58
24	N/A	24.79	37.19	49.58
25	N/A	25.25	37.87	50.50
26	13.06	26.12	39.19	52.25
27	13.54	27.08	40.62	54.16
28	14.02	28.04	42.06	56.08
29	14.54	29.08	43.62	58.16
30	15.08	30.17	45.25	60.33
31	15.74	31.48	47.22	62.96
32	16.44	32.88	49.32	65.76
33	17.14	34.28	51.42	68.56
34	17.88	35.77	53.65	71.53
35	18.67	37.33	56.00	74.66
36	19.66	39.32	58.97	78.63
37	20.71	41.42	62.14	82.85
38	21.81	43.61	65.42	87.23
39	22.97	45.93	68.90	91.86
40	24.19	48.37	72.56	96.75
41	25.52	51.05	76.57	102.10
42	26.88	53.76	80.65	107.53
43	28.34	56.69	85.03	113.38
44	29.87	59.74	89.61	119.48
45	31.48	62.96	94.43	125.91
46	33.59	67.17	100.76	134.34
47	35.88	71.76	107.65	143.53
48	38.28	76.56	114.85	153.13
49	40.91	81.82	122.73	163.64
50	43.75	87.50	131.24	174.99
51	46.43	92.85	139.28	185.71
52	49.23	98.46	147.69	196.93
53	52.22	104.45	156.67	208.89
54	55.44	110.89	166.33	221.77
55	58.87	117.75	176.62	235.49
56	57.53	115.06	172.59	230.12
57	62.02	124.05	186.07	248.09
58	66.76	133.53	200.29	267.06
59	71.78	143.55	215.33	287.11
60	77.10	154.20	231.30	308.40
61	83.55	167.09	250.64	334.19
62	90.35	180.69	271.04	361.39
63	97.54	195.08	292.63	390.17
64	105.17	210.35	315.52	420.70
65	113.22	226.45	339.67	452.90
66	125.84	251.69	377.53	503.38
67	139.17	278.35	417.52	556.69
68	153.31	306.63	459.94	613.26
69	168.37	336.74	505.12	673.49
70	184.41	368.82	553.23	737.64

MONTHLY *SMOKER* RATES

Issue Age	\$25,000	\$50,000	\$75,000	\$100,000
19	14.29	28.58	42.87	57.16
20	14.65	29.29	43.94	58.58
21	15.02	30.04	45.06	60.08
22	15.37	30.75	46.12	61.50
23	15.77	31.54	47.31	63.08
24	16.19	32.37	48.56	64.75
25	16.56	33.12	49.69	66.25
26	17.17	34.33	51.50	68.66
27	17.81	35.62	53.44	71.25
28	18.46	36.92	55.37	73.83
29	19.12	38.25	57.37	76.50
30	19.83	39.67	59.50	79.33
31	20.72	41.45	62.17	82.90
32	21.66	43.31	64.97	86.63
33	22.61	45.22	67.83	90.45
34	23.65	47.30	70.95	94.60
35	24.67	49.33	74.00	98.66
36	25.09	51.81	77.71	103.61
37	27.24	54.49	81.73	108.98
38	28.61	57.21	85.82	114.43
39	30.09	60.19	90.28	120.38
40	31.64	63.29	94.93	126.58
41	33.63	67.26	100.88	134.51
42	35.72	71.43	107.15	142.86
43	37.95	75.90	113.85	151.79
44	40.29	80.57	120.86	161.14
45	42.79	85.58	128.37	171.16
46	45.69	91.38	137.07	182.76
47	48.86	97.72	146.58	195.44
48	52.16	104.31	156.47	208.62
49	55.74	111.49	167.23	222.97
50	59.58	119.16	178.74	238.32
51	63.63	127.25	190.88	254.51
52	67.92	135.84	203.77	271.69
53	72.51	145.02	217.53	290.04
54	77.37	154.74	232.10	309.47
55	82.62	165.24	247.87	330.49
56	80.19	160.38	240.57	320.75
57	86.15	172.30	258.45	344.60
58	92.40	184.81	277.21	369.62
59	99.05	198.11	297.16	396.22
60	106.00	211.99	317.99	423.98
61	114.59	229.18	343.77	458.36
62	123.62	247.25	370.87	494.50
63	133.12	266.23	399.35	532.46
64	143.11	286.21	429.32	572.43
65	153.62	307.24	460.86	614.48
66	170.36	340.71	511.07	681.42
67	188.03	376.06	564.09	752.12
68	206.77	413.53	620.30	827.07
69	226.63	453.26	679.89	906.51
70	247.76	495.52	743.28	991.04

Protecting What Matters Most

Complete Identity Protection

PrivacyArmor offers consumers a comprehensive, proactive identity theft defense. Our proprietary technology makes InfoArmor's identity protection more than enough to help fight 21st century crime.



SNAPD^{2.0} Identity Monitoring

We monitor identities to uncover identity fraud at its inception. Now with High Risk Transaction alerts, more fraud is detected sooner, including unauthorized account access, fund transfers and password resets.



CreditArmor

CreditArmor offers an annual credit report, monthly credit scores, and monitoring of your TransUnion credit file for no additional charge. Activate these credit services in your online portal with our complements.



Internet Surveillance

By scouring an ever-evolving network of compromised machines, we detect information misuse and compromised credentials in the Underground Internet and alert consumers with unparalleled accuracy.



Digital Identity

This interactive, easy-to-read report summarizes what a real-time deep Internet search finds out about a subscriber, offers a Privacy Grade and tips to better secure personal information.



NEW
2015



Social Media Reputation Monitoring - January, 2015

We monitor your Facebook, LinkedIn, Twitter, and Instagram profile to give actionable alerts of reputational damage including racist, violent, derogatory, vulgar, or inappropriate comments. Let us keep tabs on your digital footprint so you don't have to.



Privacy Advocate Remediation

Our Privacy Advocates are CITRMS® Certified and ITRC Trained to be experts in identity restoration. If we detect suspicious activity, a Privacy Advocate will act as a dedicated case manager to act on behalf of the victim and resolve the issue from start to case completion.



\$25,000 Identity Theft Insurance Policy

Protect consumers from the financial damages of identity theft with our \$25,000 Identity Theft Insurance Policy* for associated costs, legal defense expenses, and lost wages.



Solicitation Reduction

We reduce the root cause of up to 20% of identity theft by decreasing junk mail, stopping pre-approved credit offers, and ending telemarketing calls.

Monthly Rates

Employee only - \$7.95

Family coverage - \$13.95

*Identity theft insurance underwritten by insurance company subsidiary of InfoArmor LLC. This description herein is summary and intended for informational purposes only and does not include all terms, conditions, and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Learn more about the advantages of identity monitoring.

**Keystone Learning Services
403(b) Plan Notification Form**

1. Participant Information			Location _____	
Plan Name <u>Keystone Learning Services Voluntary Sec. 403(b) Plan</u>				
Participant Name _____			<input type="checkbox"/> Male <input type="checkbox"/> Female	
First	MI	Last		
Mailing Address _____				
Street Address		City	State	Zip
Residential Address _____				
<small>(If different from mailing address)</small>				
Street Address		City	State	Zip
Social Security Number _____		Date of Birth _____	Date of Hire _____	
Daytime Phone Number _____		Home Phone Number _____		

2. I have been informed of the availability of the opportunity to participate in the voluntary Sec. 403(b) offered through my employer.	
<input type="checkbox"/> I wish to participate in the Keystone Learning Services 403(b) Plan.	
<input type="checkbox"/> I am already participating in the Keystone Learning Services 403(b) Plan.	
<input type="checkbox"/> I choose not to participate in the Keystone Learning Services 403(b) Plan.	

3. Provide Signatures	
I understand that I am eligible to participate in the Keystone Learning Services Sec. 403(b) plan.	
X _____	Date (mm/dd/yyyy)
Signature of Participant	

Approved Companies and Representatives:

Security Benefit Life

Leasa Huffman
leasahuffman@ofgfinancial.com
785-267-6556

Kate McMaster
katemcmaster@ofgfinancial.com
785--845-5501

American Fidelity Assurance Co.

Steve Schwartz
steve.schwartz@americanfidelity.com
785-232-8100

Lincoln Investment Planning

800-242-1421

403(b) PLAN HIGHLIGHTS

Participation

When am I eligible to participate in this plan?

- You are eligible to join this plan on your date of hire, and as specified by your employer.
-

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 eligible transfer. 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.
- 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 (\$18,000 in 2017).
- If you are age 50 or older you can contribute a "catch-up" contribution of up to \$6,000 (2017).

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 www.bbadmin.com


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.

Keystone Learning Services 2017 Annual Notices

1. Summary of Benefits and Coverage
2. Medicaid CHIP Notice
3. Part D Creditable Coverage Disclosure
4. General Notice of COBRA Continuation
5. Health Insurance Marketplace Information
6. HIPPA Notice of Special Enrollment Rights
7. Women's Health and Cancer Rights Notice


Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: POS

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions		Answers	Why this Matters:
What is the overall <u>deductible</u> ?		For each Plan Year, Network: Individual \$1,000 / Family \$2,000 . Out-of-Network: Individual \$2,000 / Family \$4,000 . Does not apply to office visits, prescription drugs, and preventive care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?		No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?		Yes. Network: Individual \$3,000 / Family \$6,000 . Out-of-Network: Individual \$6,000 / Family \$12,000 .	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?		Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?		No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?		Yes. See www.aetna.com or call 1-888-982-3862 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?		No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?		Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

- 
 - Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
 - The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
 - This plan may encourage you to use network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$50 copay/visit	50% coinsurance	_____none_____
	Other practitioner office visit	\$25 copay/visit	50% coinsurance	_____none_____
	Preventive care / screening /immunization	No charge	50% coinsurance, except no charge for immunizations up to age 6	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; 20% coinsurance for x-ray	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	_____none_____

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families</p> <p>Value Plus Five Tier Open Formulary</p>	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	Copay/prescription: Tier 1A \$3 for 30 day (retail), \$7.50 for 31-90 day (retail & mail order); Formulary \$12 for 30 day (retail), \$30 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: Tier 1A \$3 (retail); Formulary \$12 (retail)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Formulary brand drugs	Copay/prescription: \$50 for 30 day (retail), \$125 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: \$50 (retail)	
	Non-formulary generic/brand drugs	Copay/prescription: \$75 for 30 day (retail), \$187.50 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: \$75 (retail)	
	Specialty drugs	20% copay up to a maximum/ prescription: \$150 (formulary), \$250 (non-formulary)	50% coinsurance plus 20% copay up to a maximum/ prescription: \$150 (formulary), \$250 (non-formulary)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	20% coinsurance after \$200 copay/visit	20% coinsurance after \$200 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____
	Urgent care	\$50 copay/visit	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	20% coinsurance	50% coinsurance	_____none_____
	Mental/Behavioral health outpatient services	\$50 copay/visit	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$50 copay/visit	50% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	\$50 copay/visit	50% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$50 copay/visit	50% coinsurance	Coverage is limited to 40 visits per plan year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	\$50 copay/visit	50% coinsurance	Coverage is limited to Autism Physical, Occupational & Speech Therapy for children up to age 12; 40 visits per plan year after age 12, combined with rehabilitation services.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per plan year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	_____none_____
	Hospice service	20% coinsurance for inpatient; \$50 copay/visit for outpatient	50% coinsurance	Pre-authorization required for out-of-network care.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$50 copay/visit	50% coinsurance	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult & Child)• Glasses (Child)	<ul style="list-style-type: none">• Routine foot care• Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none">• Chiropractic care	<ul style="list-style-type: none">• Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.• Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Kansas Insurance Department, Consumer Assistance Division, (800) 432-2484, **<http://www.ksinsurance.org>**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-982-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助, 请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-982-3862.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

 This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)	
■ Amount owed to providers: \$7,540	
■ Plan pays: \$5,630	
■ Patient pays: \$1,910	
Sample care costs:	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$1,000
Copays	\$10
Coinsurance	\$700
Limits or exclusions	\$200
Total	\$1,910

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
■ Amount owed to providers: \$5,400	
■ Plan pays: \$3,920	
■ Patient pays: \$1,480	
Sample care costs:	
Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$1,000
Copays	\$200
Coinsurance	\$200
Limits or exclusions	\$80
Total	\$1,480

Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?


✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs


Coverage for: Individual + Family | Plan Type: POS

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions		Answers	Why this Matters:
What is the overall <u>deductible</u> ?		For each Plan Year, Network: Individual \$5,000 / Family \$10,000 . Out-of-Network: Individual \$10,000 / Family \$20,000 . Does not apply to office visits, prescription drugs, and preventive care in-network.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?		No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?		Yes. Network: Individual \$6,350 / Family \$12,700 . Out-of-Network: Individual \$12,500 / Family \$25,000 .	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?		Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?		No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?		Yes. See www.aetna.com or call 1-888-982-3862 for a list of network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?		No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?		Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

- 
 - Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
 - The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
 - This plan may encourage you to use network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$60 copay/visit	50% coinsurance	_____none_____
	Other practitioner office visit	\$25 copay/visit	50% coinsurance	_____none_____
	Preventive care /screening /immunization	No charge	50% coinsurance, except no charge for immunizations up to age 6	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; 50% coinsurance for x-ray	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	_____none_____

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families</p> <p>Value Plus Five Tier Open Formulary</p>	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	Copay/prescription: Tier 1A \$3 for 30 day (retail), \$7.50 for 31-90 day (retail & mail order); Formulary \$12 for 30 day (retail), \$30 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: Tier 1A \$3 (retail); Formulary \$12 (retail)	<p>Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.</p> <p>_____none_____</p> <p>_____none_____</p> <p>_____none_____</p> <p>_____none_____</p> <p>No coverage for non-emergency use.</p> <p>_____none_____</p> <p>No coverage for non-urgent use.</p> <p>Pre-authorization required for out-of-network care.</p>
	Formulary brand drugs	Copay/prescription: \$40 for 30 day (retail), \$100 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: \$40 (retail)	
	Non-formulary generic/brand drugs	Copay/prescription: \$65 for 30 day (retail), \$162.50 for 31-90 day (retail & mail order)	50% coinsurance after copay/prescription: \$65 (retail)	
	Formulary specialty drugs	20% copay up to a maximum/ prescription: \$150 (formulary), \$250 (non-formulary)	50% coinsurance plus 20% copay up to a maximum/ prescription: \$150 (formulary), \$250 (non-formulary)	
	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	
<p>If you have outpatient surgery</p>	Physician/surgeon fees	50% coinsurance	50% coinsurance	<p>_____none_____</p> <p>No coverage for non-emergency use.</p> <p>_____none_____</p> <p>No coverage for non-urgent use.</p> <p>Pre-authorization required for out-of-network care.</p>
	Emergency room services	50% coinsurance after \$200 copay/visit	50% coinsurance after \$200 copay/visit	
	Emergency medical transportation	50% coinsurance	50% coinsurance	
<p>If you need immediate medical attention</p>	Urgent care	\$50 copay/visit	50% coinsurance	<p>_____none_____</p> <p>No coverage for non-emergency use.</p> <p>Pre-authorization required for out-of-network care.</p>
	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	
<p>If you have a hospital stay</p>				

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	50% coinsurance	50% coinsurance	_____none_____
	Mental/Behavioral health outpatient services	\$60 copay/visit	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	50% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$60 copay/visit	50% coinsurance	_____none_____
	Substance use disorder inpatient services	50% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	_____none_____
	Delivery and all inpatient services	50% coinsurance	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	\$60 copay/visit	50% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$60 copay/visit	50% coinsurance	Coverage is limited to 40 visits per plan year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	\$60 copay/visit	50% coinsurance	Coverage is limited to Autism Physical, Occupational & Speech Therapy for children up to age 12; 40 visits per plan year after age 12, combined with rehabilitation services.
	Skilled nursing care	50% coinsurance	50% coinsurance	Coverage is limited to 60 days per plan year. Pre-authorization required for out-of-network care.
	Durable medical equipment	50% coinsurance	50% coinsurance	_____none_____
	Hospice service	50% coinsurance for inpatient; \$60 copay/visit for outpatient	50% coinsurance	Pre-authorization required for out-of-network care.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	\$60 copay/visit	50% coinsurance	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult & Child) Glasses (Child) 	<ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing Routine foot care Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition. Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: POS

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Kansas Insurance Department, Consumer Assistance Division, (800) 432-2484, <http://www.ksinsurance.org>

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$2,730
- Patient pays: \$4,810

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,600
Copays	\$10
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$4,810

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$2,920
- Patient pays: \$2,480

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,300
Copays	\$100
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,480

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Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs


Coverage for: Individual + Family | Plan Type: POS

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling **1-888-982-3862**.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	For each Plan Year, Network: Individual \$2,600 / Family \$5,200 . Out-of-Network: Individual \$2,600 / Family \$5,200 . Does not apply to preventive care in-network.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Network: Individual \$3,500 / Family \$7,000 . Out-of-Network: Individual \$7,000 / Family \$14,000 .	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. See www.aetna.com or call 1-888-982-3862 for a list of network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS

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 - Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
 - The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
 - This plan may encourage you to use network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	0% coinsurance	20% coinsurance	_____none_____
	Other practitioner office visit	0% coinsurance	20% coinsurance	_____none_____
	Preventive care / screening /immunization	No charge	20% coinsurance, except no charge for immunizations up to age 6	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	_____none_____

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families</p> <p>Value Five Tier Open Formulary</p>	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	After deductible, copay/prescription: Tier 1A \$3 for 30 day (retail), \$7.50 for 31-60 day (retail & mail order); Formulary \$12 for 30 day (retail), \$30 for 31-60 day (retail & mail order)	After deductible, 20% coinsurance after copay/prescription: Tier 1A \$3 (retail); Formulary \$12 (retail)	Covers 30 day supply (retail), 31-60 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Formulary brand drugs	After deductible, copay/prescription: \$50 for 30 day (retail), \$125 for 31-60 day (retail & mail order)	After deductible, 20% coinsurance after copay/prescription: \$50 (retail)	
	Non-formulary generic/brand drugs	After deductible, copay/prescription: \$75 for 30 day (retail), \$187.50 for 31-60 day (retail & mail order)	After deductible, 20% coinsurance after copay/prescription: \$75 (retail)	
	Formulary specialty drugs	After deductible, 20% copay up to a maximum/prescription: \$150 (formulary), \$250 (non-formulary)	After deductible, 20% coinsurance plus 20% copay up to a maximum/prescription: \$150 (formulary), \$250 (non-formulary)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	—none—
	Physician/surgeon fees	0% coinsurance	20% coinsurance	—none—
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	0% coinsurance	0% coinsurance	—none—
	Urgent care	0% coinsurance	20% coinsurance	No coverage for non-urgent use.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	0% coinsurance	20% coinsurance	_____none_____
	Mental/Behavioral health outpatient services	0% coinsurance	20% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	0% coinsurance	20% coinsurance	_____none_____
	Substance use disorder inpatient services	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	_____none_____
	Delivery and all inpatient services	0% coinsurance	20% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	0% coinsurance	20% coinsurance	Coverage is limited to 40 visits per plan year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	0% coinsurance	20% coinsurance	Coverage is limited to Autism Physical, Occupational & Speech Therapy for children up to age 12; 40 visits per plan year after age 12, combined with rehabilitation services.
	Skilled nursing care	0% coinsurance	20% coinsurance	Coverage is limited to 60 days per plan year. Pre-authorization required for out-of-network care.
	Durable medical equipment	0% coinsurance	20% coinsurance	_____none_____

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Hospice service	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
	Eye exam	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cco.cms.gov.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: POS**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Kansas Insurance Department, Consumer Assistance Division, (800) 432-2484, <http://www.ksinsurance.org>

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-982-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助, 请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-982-3862.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$4,730
- Patient pays: \$2,810

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,600
Copays	\$10
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$2,810

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$2,650
- Patient pays: \$2,750

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,600
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,750

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.

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Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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 January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Important Notice from Keystone Learning Services About Your Prescription Drug Coverage and Medicare

This Notice pertains to the Aetna POS Plans

(INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE OMB 0938-0990)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Keystone Learning Services Group Health Care Plan 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. Aetna has determined that the prescription drug coverage offered by the Keystone Learning Services Group Health Care 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.

CMS Form 10182-CC

CMS Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 Keystone Learning Services Group Health Plan coverage will not be affected. Please refer to the Aetna Health Care Plan Summary document for an explanation of the prescription drug coverage plan provisions/options under the Keystone Learning Services Group Health Care Plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Keystone Learning Services Group Health Care Plan coverage, be aware that you and your dependents will not be able to get this coverage back unless you reenroll on the active employee group health plan during the annual open enrollment period or experience a mid-year qualifying status change event.

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 the Keystone Learning Services Group Health Care Plan 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 get it before the next period you can join a Medicare drug plan, and if this coverage through the Keystone Learning Services Group Health Care Plan 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).

Dated: May 1, 2017

Keystone Learning Services

Jenny Carter

785-876-2214

jcarter@keystonelearning.org

CMS Form 10182-CC

CMS Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA ****

Introduction

You are receiving this notice because you have recently become or may become covered under the Keystone Learning Services Group Health Care Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** 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 coverage would otherwise end because of a life event. This is also called as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Johnson County Community College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Jenny Carter, 500 E. Sunflower Blvd., Ozawie, KS 66070, 785-876-2214 or jcarter@keystonelearningservices.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 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 receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to determine if you or a covered member of your family qualify for the disability extension, you must send documentation received from Social Security verifying the disability determination to Jenny Carter at 500 E. Sunflower Blvd., Ozawie, KS 66070, 785-876-2214 or jcarter@keystonelearningservices.org.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. 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, 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.

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

Dated: May 1, 2017
Keystone Learning Services
Jenny Carter
785-876-2214
jcarter@keystonelearning.org



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 4-30-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in November 2015 for coverage starting as early as January 1, 2016.

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: **Jenny Carter at 500 E. Sunflower Blvd., Ozawie, KS 66070, 785-876-2214 or jcarter@keystonelearningservices.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.

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.

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.

3. Employer name Keystone Learning Services		4. Employer Identification Number (EIN) 48-0840310	
5. Employer address 500 E. Sunflower Blvd		6. Employer phone number 785-876-2214	
7. City Ozawkie	8. State KS	9. ZIP code 66070	
10. Who can we contact about employee health coverage at this job? Jenny Carter			
11. Phone number (if different from above)		12. Email address jcarter@keystonelearning.org	

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

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

All employees. Eligible employees are:

- ☒ Full-time employees working 30 hours or more per week.

- ☐ Some employees. Eligible employees are:

- With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are:
The employee's spouse & dependent children.

- ☐ We do not offer coverage.

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

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

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice is being provided to insure that you understand your right to apply for the Keystone Learning Services Group Health Care Plan. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify us within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.**

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. During the year you get married. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Dated: May 1, 2017
Keystone Learning Services
Jenny Carter
785-876-2214
jcarter@keystonelearning.org

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Keystone Learning Services is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Keystone Learning Services Group Health Care Plan provides coverage for mastectomies and the related procedures listed above, subject to the same copays, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Aetna Group Health Care Plan Summary Document or contact your plan administrator at:

Dated: May 1, 2017

Keystone Learning Services

Jenny Carter

785-876-2214

jcarter@keystonelearning.org

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The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your Benefits Manager.