Guide to Your 2018 Employee Benefits Program

A Message from the Superintendent

Dear R-7 Staff Members,

In September 2017, the Lee’s Summit R-7 School District was awarded a Bronze Level Healthy KC Certification. Healthy KC is a partnership with Blue Cross and Blue Shield of Kansas City and the Greater Kansas City Chamber of Commerce. The award, with four levels of certification (gold, silver, bronze and honorable mention), is based on an organization’s efforts to create a workplace focused on health and wellbeing. The wellbeing certification is based on four pillars of health: nutrition, physical activity, tobacco cessation and work/life integration.

Our goal, as a district, is working toward the “gold” certification. To that end, the District’s Employee Wellbeing Program has recently expanded to better serve our employees. We are taking a whole-person approach to inspire balance in holistic wellbeing while continuing our commitment to becoming and staying healthy. Employees can assist in this effort by choosing to live a healthy lifestyle through diet and exercise, by scheduling preventive annual and age-appropriate screenings and by actively participating in the District’s Employee Wellbeing Program.

In addition to the District’s Employee Wellbeing Program, I encourage you to utilize the following District wellbeing resources:

- Complete Health and Wellness Center operated by CareHere
- Blue Cross and Blue Shield Wellbeing programs
- Employee Assistance Program (EAP), known as LifeMatters and provided by Empathia
- VALIC financial services provided through CSD Retirement Trust.

For more information on the wellbeing resources available to you, please review the information in this guide, visit wellbeing.lsr7.net or contact the District’s Wellbeing Coordinator, Jennifer Flax.

We truly believe if our employees are healthy, happy and thriving in all elements of wellbeing, students will directly benefit. Thank you in advance for your continued support and active participation. I look forward to joining you in pursuit of our wellbeing goals.

Yours in the work,

Dennis L. Carpenter, Ed.D
Superintendent
Introduction

Welcome to the Lee’s Summit School District Benefits Program. This guide provides information detailing the benefit programs and options available to you as an employee of the Lee’s Summit R-VII School District. The benefits available to employees are designed to provide a variety of options. As an eligible employee it is important to understand those options and how to make the best choices for your specific situation and individual needs. As needs change, you may have the opportunity to make changes to coverage, either as a new enrollee, during annual open enrollment or mid-year when experiencing a qualifying status change.

Special Note

The purpose of this guide is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this guide. If there is any discrepancy between the descriptions of the Plans as described in this material and the official Plan documents, the language of the documents shall govern. Lee’s Summit School District also specifically reserves the right to revise, modify or terminate the Plans at any time.


Anti-Discrimination

In accordance with the provisions of the Americans With Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964 (as amended), Title IX of the Educational Amendments of 1972, P.L. 93-112, and Section 504 of the Rehabilitation Act of 1973 and the regulations thereunder, it is the policy of the Lee's Summit R-7 School District that no person shall, because of age, sex, race, disability, or national origin be excluded from participation in, be denied the benefits of, or subjected to discrimination under any education program or activity of the District, including the employment of staff personnel.

Written district policies concerning the rights and responsibilities of employees and students are available for inspection at the Stansberry Leadership Center (R-7 Administrative Offices) located at 301 NE Tudor.

Inquiries by persons about their protection against discrimination under The Americans with Disabilities Act, Title IX, Title VI, or P.L. 93-112 and the Section 504 may be directed in writing or by telephone to:

Dr. Jeffrey C. Miller
Associate Superintendent of Human Resources
Lee’s Summit R-7 School District
301 NE Tudor Road
Lee’s Summit, MO 64086
(816) 986-1000
Summary of 2018 Plan Changes

Each year the District evaluates the benefit plans and insurance carriers to ensure your benefits remain competitive, cost-effective and provide relevant services. A brief summary of the 2018 changes is provided below, which are described in more detail throughout this guide:

- The 2018 Health Savings Account (HSA) maximum contributions for those enrolled in a High Deductible Health Plan (HDHP) with employee only coverage will increase to $3,450, up from $3,400 (the 2017 maximum). The maximum HSA contribution for those enrolled with dependents will increase to $6,900, up from $6,750 (the 2017 maximum). The limit includes the District HSA contribution and any voluntary employee contributions.
- Chiropractic manipulation copay of $40 added to the HMO plans.
- Adding a second High Deductible Health Plan (HDHP) utilizing the BlueSelect Plus network.
- Adding a second retail pharmacy network, Express Advantage Pharmacy (EAN) retail to all medical plans. HMO and PPO members will pay an additional $10 copay at any retail pharmacy outside the EAN.
- Dental carrier changing from Delta Dental of Missouri to Cigna.
- Blended/progressive lenses copay of $30 and a $180 featured frame brand allowance added to both vision plans.
- Long Term Disability (LTD) increase in assisted living benefit to 100% of pre-disability earnings for those unable to perform two or more activities of daily living or suffering severe cognitive impairment; maximum benefit cannot exceed $5,000 in addition to the LTD benefit.

Who Is Eligible and When?

You are eligible to participate in the Lee’s Summit School District benefits program if you are a regularly scheduled (full- and part- time) staff member receiving compensation included in a District contract and/or compensation summary or as required by law. Regularly scheduled is defined as working in a position required during the hours and days of the student attendance calendar authorized for the school term. The District’s contribution towards medical coverage for part-time employees is pro-rated based on the position and the number of hours worked. The costs illustrated in this guide apply to full-time employees.

If you are a new hire, you are eligible to select among the Lee’s Summit School District options effective the first of the second month following date of hire. Date of hire is defined as the first day of an employee’s contract and/or compensation summary. For example, if employment starts anytime in September, insurance coverage will begin on November 1st.

To confirm your insurance coverage begin date, please contact the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

If this is your annual open enrollment period, changes will be effective January 1, 2018.

You may elect medical, dental, vision and life insurance coverage for your eligible dependents.

For Medical, Dental and Vision Insurance, eligible dependents include:

- Your legal spouse.
- Your dependent children (through the end of the calendar year in which they turn age 26).
- When approved, your dependent children over age 26 who are incapable of self-care because of a handicap, and who rely on you for support.

For Life Insurance, eligible dependents include:

- Your legal spouse.
- Your unmarried dependent children (through the end of the calendar year in which they turn age 26).
- When approved, your dependent children over age 26 who are incapable of self-care because of a handicap, and who rely on you for support.
- Your spouse and/or dependent children must not be full-time members of the Armed Forces.

When Payroll Deductions Begin for These Selections

Payroll deductions for benefits that go into effect January 1, 2018 will begin with your December 2017 paycheck(s). If applicable, HSA and HRA contributions will be begin with your January 2018 paycheck(s).

Payroll deductions for benefits that go into effect after January 1, 2018 will begin one month prior to your insurance coverage start date. If applicable, HSA and HRA contributions will begin in the month your coverage starts.
Making Changes During the Year

The benefit options selected when you first become eligible and/or during the annual open enrollment will remain in effect throughout the calendar year unless you experience an eligible qualifying event. If you experience an eligible qualifying event (defined on page 5) during the calendar year, you may request changes to your insurance plans for yourself or eligible family members. (Please note: If you are adding family members mid-year, they must be added to the plan you are currently enrolled in. A mid-year change will not allow you to change plans.)

You do NOT have the option of selecting the effective date. Your change in coverage will be effective based upon your qualifying event date.

Your change request and ALL required documentation must be received by the Business Services Department within 31 calendar days of the qualifying event date. (For gain or loss of Medicaid or Medicare, documentation must be provided within 60 calendar days of the qualifying event.) The changes you request must be consistent with the qualifying event.

Eligible Qualifying Events

An eligible qualifying event includes any of the following:

- Adoption, birth, or placement for adoption of a child;
- Employment status change (reduction in hours or termination of employment) for you, your spouse, or your dependent;
- Enrollment in a plan through the Federal Marketplace/Exchange;
- Gain or loss of Medicaid or Medicare entitlement;
- Guardianship of a child (full and legal);
- Judgment, decree, or order mandating alternative coverage for a child;
- Legal separation, or divorce;
- Loss of eligibility for other coverage* (no longer qualify as an eligible dependent under the other coverage or end of COBRA or state continuation coverage) for you, your spouse, or your dependent;
- Marriage; or
- Open enrollment for a spouse or dependent.

*Loss of eligibility for coverage does NOT include termination of coverage due to untimely payment of premiums or termination for cause. Also dropping or cancelling an individual insurance plan, is NOT an eligible qualifying event.
How to Request a Mid-Year Change, Effective Date & Premium Impact

To request changes for yourself and/or eligible family members to your insurance plans mid-year, due to an eligible qualifying event, ALL of the following must be received in the Business Services Department at the Stansberry Leadership Center within 31 calendar days of the qualifying event date. (For gain or loss of Medicaid or Medicare, documentation must be provided within 60 calendar days of the qualifying event.)

1. Insurance Change form accurately completed and signed (this form can be found in the Forms section of Employee Online or at the Business Services Department);
2. Appropriate documentation verifying the qualifying event (see chart below for acceptable documentation); AND
3. Additional premium due, if coverage is being added, paid by check (made payable to Lee’s Summit R-VII School District) or cash. If requested, a receipt of payment will be provided to you.

If ALL of these items are not received within the specified number of days, you will be unable to make a mid-year change and will have to wait until the next open enrollment period to make changes to your benefits.

For additional questions regarding mid-year changes, please contact the Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

Based upon the type of qualifying event, please use the following chart to determine the acceptable documentation, effective date of coverage and premium impact.

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Acceptable Documentation</th>
<th>Effective Date of Coverage</th>
<th>Premium Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption or placement for adoption of child</td>
<td>Copy of finalized court documents indicating date of event.</td>
<td>Earlier of: the moment of birth for a newborn child if a petition for adoption was filed within 31 days of the birth of the child; the date the petition for adoption was filed; or date of child's placement**</td>
<td></td>
</tr>
<tr>
<td>Birth of child</td>
<td>Birth certificate, Hospital Crib Card or Hospital invoice showing name and date of child's birth.</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Employment Status Change (reduction in hours or termination of employment)</td>
<td>If you, no forms required. If spouse or dependent, letter/form from spouse's or dependent's old or new employer indicating the gain or loss of employment. Letter/form must indicate last date of coverage or first date coverage is available.</td>
<td>First day following the date the other coverage terminates or day prior to the date coverage begins.</td>
<td></td>
</tr>
<tr>
<td>Enrollment in a Federal Market-place/Exchange Plan</td>
<td>Copy of enrollment verification which indicates coverage start date.</td>
<td>Day prior to the date coverage begins.</td>
<td></td>
</tr>
<tr>
<td>Gain or loss of Medicaid or Medicare Entitlement</td>
<td>Letter/form indicating the gain or loss of coverage. Letter/form must indicate last date of coverage or first date coverage is available.</td>
<td>First day following the date the other coverage terminates or day prior to the date coverage begins.</td>
<td>Premium is not required or will not be reimbursed if the Qualifying Event date is on or after the 15th of the month.</td>
</tr>
<tr>
<td>Guardianship of child (full and legal)</td>
<td>Copy of court order awarding full guardianship.</td>
<td>Date of legal guardianship as indicated in court documents.</td>
<td></td>
</tr>
<tr>
<td>Judgement, decree, or order mandating alternative coverage for a child</td>
<td>Copy of medical support order or court document.</td>
<td>Date indicated in medical support order or court documents.</td>
<td></td>
</tr>
<tr>
<td>Legal Separation or Divorce</td>
<td>Spouse: Copy of finalized court documents indicating date of event. Child(ren): Copy of finalized court documents indicating the date of event. If coverage is not court ordered, must supply a letter/form indicating the gain or loss of coverage. Letter/form must indicate last date of coverage or first date coverage is available.</td>
<td>First day following the date the other coverage terminates or day prior to the date coverage begins.</td>
<td></td>
</tr>
<tr>
<td>Loss of Eligibility for Other Coverage ***</td>
<td>Letter/form indicating the date you, your spouse/dependent are no longer eligible.</td>
<td>First day following the date the other coverage terminates or day prior to the date coverage begins.</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>Marriage certificate indicating both parties and date of marriage.</td>
<td>Date of Marriage</td>
<td></td>
</tr>
<tr>
<td>Open Enrollment for Spouse or Child</td>
<td>Letter from spouse’s or dependent’s employer indicating an open enrollment change. Letter must indicate last date of coverage or first date coverage is available.</td>
<td>First day following the date the other coverage terminates or day prior to the date coverage begins.</td>
<td></td>
</tr>
</tbody>
</table>

**Date of placement means the date you assume the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.

*** Loss of eligibility for coverage does NOT include termination of coverage due to untimely payment of premiums or termination for cause. Also, dropping or cancelling an individual insurance plan is NOT an eligible qualifying event.
How to Enroll

All eligible employees, including new hires, must complete the on-line enrollment process, even if you wish to keep the same coverage or are waiving coverage. If you do not complete your enrollment by the deadline given to you by the District, you will not have coverage for the entire plan year.

You may complete your enrollment from any computer that has internet access. Pop-up blockers must be turned off on your computer in order to complete the on-line enrollment process. It is very important you complete your enrollment by the deadline given to you by the District.

To enroll, follow these steps to ensure completion of your enrollment:

**Step 1:** Review the information contained in this guide to assist you in making your benefit choices for 2018.

**Step 2:** Go on-line to [http://benefits.lsr7.org](http://benefits.lsr7.org) anytime day or night. Click on the “Enroll Now.” You are now at the insurance enrollment site.

Your user ID and PIN are as follows:

**User ID:** Your User ID is the first letter of your legal first name, first letter of your last name, and the last four digits of your social security number.

For example, John Smith, SSN ending in 1234: User ID is JS1234.

**PIN:** Your PIN is equal to your date of birth. Please enter two digits for month, two digits for day and four digits for year.

For example, date of birth of March 10, 1980: PIN is 03101980.

Once logged in, click on “Enroll/Change your benefits,” then click on “Plan Year Beginning January 1, 2018” and then click on “Health and Welfare Benefits Enrollment” to make elections for 2018. Work through the site by following the on-line instructions.

**Step 3:** Upon completion of Step 2, a confirmation statement will appear on the page. If the information is accurate, print a copy for your records, and click “Confirm.” You will then receive a confirmation number. Write this number down or print the page for your records. If you do NOT receive a confirmation number, your insurance elections will not be processed.

**Step 4:** FOR FIRST TIME HEALTH SAVINGS ACCOUNT ENROLLEES (HIGH DEDUCTIBLE HEALTH PLAN ENROLLEES ONLY): If you are electing to have the District’s contribution deposited into a Health Savings Account (HSA) for the first time, then you must set up your HSA through Central Bank of the Midwest using the steps shown on page 23. The District will make contributions only to Central Bank of the Midwest HSA accounts.

If you do not have internet access or have questions regarding the enrollment process or need assistance enrolling, please contact the Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

Once you have enrolled in the District group benefit plans and voluntary benefit plans, making use of the benefits can sometimes be a challenge. You may have questions and that is why the District makes assistance available to you and your dependents. We encourage you to call the carrier first for questions you may have, or visit the carrier websites to locate participating providers, request an id card, and view your claims or to access members-only resources. If you do not get resolution to your satisfaction, please contact the District’s Business Service Department at (816) 986-1000 or by email at benefits@lsr7.net.


Inspiring Balance: Employee Wellbeing Program

The vision of the Inspiring Balance, Employee Wellbeing Program is to: Inspire and empower each employee of the LSR7 family to champion their own personal pathway to a balanced wellbeing. The mission is to support, engage, empower and equip each employee of the LSR7 family with the programs, services, resources and culture necessary to achieve a balanced state of wellbeing.

The District aims to offer a comprehensive wellbeing program which focuses on the whole person empowering each employee to build on their personal strengths. One of the goals is to provide opportunities for employees to become aware of their personal health status, and to be highly effective at managing their health and self-care.

To that end, the District offers annual health screenings for employees enrolled in a District medical plan. This is an opportunity to get a snapshot of your health, and stay up-to-date on your health status.

In addition, we offer a wide variety of programs which focus on multiple aspects of wellbeing. For example, a building physical activity challenge may help you focus on physical wellbeing, while also getting more involved with your coworkers and improving relational wellbeing.

As healthcare costs continue to rise, practicing self-care, staying on top of personal health management, and focusing on wellbeing are the most effective ways we can work together to maintain a cost effective healthcare environment.
Health Screening and Health Risk Appraisal

The first step in determining your personal health risks is to complete an annual Health Risk Appraisal (HRA) and a biometric screening. You will have the opportunity to complete these every year. You will receive communication yearly about the timelines for completing both parts of the screening and HRA.

The information from the health screening is important for you, as it will allow you to stay up-to-date on crucial numbers like your weight, cholesterol levels, blood pressure and blood sugar.

You will also answer questions about indicators of other areas of wellbeing, such as your ability to manage stress and your career and life satisfaction. The data is confidential on an individual level and shared only in aggregate reporting, with all identifying information removed.

The data from health screening is used to measure the effectiveness of the District’s programming, and help drive beneficial changes to provide the most pertinent information to staff.

Your Wellbeing Resources

Blue KC: A Healthier You Program (Available only to employees enrolled in a District Blue KC medical plan)

Visit the Blue KC member website (www.mybluekc.com) to stay up-to-date on the latest health news and articles on topics as varied as nutrition, physical activity, sun safety and cancer screening. If you are dealing with a specific health condition, you can also sign up for Condition Newsletters for articles, recipes and treatment advice for health conditions such as asthma, diabetes, high cholesterol and more.

Utilize the Blue 365 program, which offers discounts on weight loss plans, fitness centers and more, just for being a member of Blue KC!

Sign in to A Healthier You Member Portal to access your personalized wellness plan and sign up for Blue KC onsite programs and webinars.

Blue KC offers onsite health coaching with a wellness coach at no charge. You have the opportunity to meet monthly with a coach to set wellness goals and receive help as you work toward them.

CareHere Health Coaches (Available only to employees enrolled in a District Blue KC medical plan)

CareHere offers wellness services at no cost to help you along your journey toward a healthier life. CareHere can help you eat better, move more, live well and be happy. CareHere offers health coaching services, CareHere Connect, CareHere Talk, CareHere Kitchen, Teaching Tuesdays and HealthMatters.

If you would like to speak with one of CareHere’s health coaches or learn more about any of these services, you may email wellness@carehere.com or call 1.877.866.6430.

Inspiring Balance Website

To access the District’s Inspiring Balance website:
2. You will find information on the Culture of Wellbeing, Wellbeing Teams, Wellbeing Initiatives, success stories of fellow employees and much more.

Employee Assistance Program (EAP)

When you or your family need useful ideas, lifestyle coaching, helpful resources or reliable professional care, LifeMatters, the District’s Employee Assistance Program (EAP) and WorkLife Service, is just a phone call or click away. LifeMatters is provided by Empathia, Inc., an independent consultation firm. Life Matters is available at no cost to all employees, legal spouses and dependent children through the end of the calendar year in which they turn 26.

Professional counselors are available to provide you confidential assistance with emotional/mental wellbeing, relationships, finances, health, legal, drug and alcohol abuse and workplace issues. Coaches are also available for career and leadership development.

Each eligible member may receive up to six face to face visits, per issue, per year at no cost. If additional services are recommended, the EAP counselor will facilitate a referral to a self-help group, a behavior health professional, an attorney, financial planner, physician, hospital or other appropriate resource. You will be responsible for the costs of all resources beyond which the EAP counselor provides.

For additional information or to schedule an appointment, call LifeMatters at 1.800.634.6433 and speak with a certified Consultation Specialist.

LifeMatters is available 24 hours a day, every day of the year.

LifeMatters provides District employees access to a website, https://www.mylifematters.com/, which offers a variety of personal health and wellbeing information, and an extensive library of references materials, resources and tools on virtually every component of wellbeing. As an added benefit, employees have access to a personalized EAP website, which lists all available services, as well as health and wellbeing resources which can be viewed confidentially. The username to access this site is LSSD1.

For more information about the Inspiring Balance Employee Wellbeing Program, please contact the District’s Wellbeing Coordinator at 816.986.1135.
Complete Health & Wellness Center

The Complete Health & Wellness Center is a benefit offered by the District in collaboration with CareHere. The health and wellness center will treat acute illness and minor injuries, prescribe medications, assist with chronic conditions, provide preventive care exams and focus on supporting the overall health of employees, retirees and their families. The center will also assist in treating work-related injuries. The center offers primary care services and is not intended to replace your current primary care physician relationship; rather it is intended to provide a convenient and affordable option to receive immediate health care, supplement your current primary care physician relationship and provide preventive health and wellbeing services. In compliance with HIPAA (Health Insurance Portability and Accountability Act), your personal health information is completely confidential and will not be shared with the District.

Center Use

The following individuals participating in a District medical plan are eligible to receive care in the Complete Health & Wellness Center:

- District employees and pre-Medicare retirees
- COBRA/LTD participants
- Spouses and dependents over the age of 2

All District employees, regardless of enrollment, are eligible to receive care for work-related injuries and occupational health services.

Location and Hours

The Complete Health & Wellness Center is conveniently located on the first floor of the Summit Ridge Medical Plaza, 600 NW Murray Road, Suite 103, Lee’s Summit, Missouri. Parking is available on the west side of the building, near the circle drive. The center phone number is 1.877.423.1330.

Hours of operation are as follows and are subject to change:
Monday-Thursday: 7:00 am-6:00 pm*
Friday: 7:00 am-12:00 pm
Saturday: 8:00 am-11:00 am
Sunday: Closed
*Closed one hour each day for lunch

Complete Health & Wellness Center is closed New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day. When a holiday falls on a non-workday the holiday will be observed on Monday (if the holiday falls on Sunday) or Friday (if the holiday falls on Saturday).

Center Staff

The center is staffed by Nurse Practitioners, a medical assistant and a registered nurse. Consistent with state requirements, the center includes oversight by a supervising physician. The Nurse Practitioners staffing the clinic are, at the minimum, Master’s Degree educated registered nurses licensed to prescribe medications, order diagnostic tests, and diagnose and treat medical conditions.

Services Offered

The Complete Health & Wellness Center is a resource to manage your acute illnesses and minor injuries, prescribe medications, assist with chronic conditions, provide preventive care exams and support the overall health and wellbeing of you and your family.

Examples of services provided at the center:

Preventive Care
- Physical exams (annual including well women/men, school, sports, and camp)
- Routine preventive lab work, including periodic blood monitoring
- Health Risk Assessments

Vaccinations
- Hepatitis A & B
- Pneumonia
- Seasonal flu (ages 2+)
- Shingles
- TB testing
- Tdap
- Tetanus
- Travel immunizations
- Other vaccinations may be available; call CareHere at 1.877.423.1330 to confirm availability

Wellbeing Services provided by
- Behavioral Health Coach
- Care Coordinator
- Exercise Physiologist
- Registered Dietitian
- Registered Nurse
- Tobacco Cessation Coach

Minor Injuries
- Cuts and Stitches
- Muscle and joint pain
- Sprains and strains

Medication
- Prescribe medication, after thorough assessment
Acute Illness (Ages 2+)

- Allergy care
- Cold and flu symptoms
- Disease management for chronic conditions (diabetes, hypertension, high cholesterol, asthma, for example)
- Ear infections
- Minor cuts
- Mole removal
- Non-preventive lab work
- Sinus infections
- Skin conditions
- Sore throat
- Upper respiratory conditions
- Urinary tract infections
- Viral and bacterial infections

Workers’ Compensation

- Work injury treatment and management
- Manage referrals and provide recommendation on injury trends

Occupational Health

- Return-to-work physicals
- Driver physicals
- Drug screenings

If you are unsure whether a medical issue can be addressed by health and wellness center staff, please call CareHere directly at 1.877.423.1330.

Cost of Services

Preventive care and wellbeing resources are available at no cost.

Non-preventive services may require minimal copay based upon medical plan enrollment as follows:

<table>
<thead>
<tr>
<th>Visit Fee Schedule</th>
<th>Preventive Care Visit or Lab Work</th>
<th>Non-Preventive Care Visit or Lab Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO, PPO, or HDHP with Health Reimbursement Arrangement</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>HDHP with Health Savings Account</td>
<td>$0</td>
<td>$20, until deductible met</td>
</tr>
</tbody>
</table>

1 Due to IRS regulations, a minimal visit fee is required for non-preventive visits.

Please Note: If applicable, payment will be collected at time of service via a credit, debit or HSA card. Cash/check not accepted.

Registration with CareHere/Scheduling an Appointment

Use of the Complete Health & Wellness Center is by appointment only. No walk-ins are allowed. By having a scheduled appointment, there should be little to no wait time. Same day appointments may be available. Appointments can be scheduled online at www.CareHere.com or by phone at 1.877.423.1330.

Before you can schedule an appointment, you must first register with CareHere (you cannot register until your insurance start date). Each eligible participant must be registered separately. You will need one of the following access codes to complete your registration:

<table>
<thead>
<tr>
<th>Health Insurance Plan</th>
<th>Access Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue-Care HMO Plans</td>
<td>LSR72</td>
</tr>
<tr>
<td>Preferred-Care Blue PPO Plan</td>
<td>LSR72</td>
</tr>
<tr>
<td>High Deductible Health Plan, with Health Reimbursement Account (HRA)</td>
<td>LSR72</td>
</tr>
<tr>
<td>High Deductible Health Plan, with Health Savings Account (HSA)</td>
<td>LSRH8</td>
</tr>
</tbody>
</table>

There are two ways to complete registration with CareHere:
1. Call 1.877.423.1330
   OR
2. Follow the steps below at www.CareHere.com to register:
   a. Click Member Login
   b. Click Register with my Access Code
   c. Enter your Access Code (use above chart to determine correct access code)
   d. Click Go
   e. Provide responses to all questions on the next four web pages of the health questionnaire, including Contact Data and Health and Behavioral Data.

Be sure to keep your CareHere login information.

For questions, please contact CareHere at 1.877.423.1330 or email benefits@lsr7.net.
Medical Insurance

Among the most important decisions you will make about your benefits through the Lee’s Summit School District is what type of medical insurance coverage is best for you and your family. This coverage helps to protect you and your family from the financial loss or hardship that could result from illness.

Terminology

Before you read further about your medical benefit choices, there are some terms you will need to understand.

Coinsurance

Coinsurance is the percentage of your medical bill you share with Blue KC after you’ve paid your deductible. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers were utilized.

Copayment

Copayment or copay refers to a fixed cost you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician and pharmacy).

Covered Expenses

Covered expenses are the healthcare expenses eligible for reimbursement. All of the medical coverage options generally provide benefits for medically necessary services and supplies ordered by a doctor for the treatment of an accidental injury, sickness or pregnancy. Each option also provides benefits for certain routine and preventive services.

Deductible

The deductible is a set amount of your covered expenses you must pay each calendar year before Blue KC begins to pay. The individual deductible is the amount each covered family member must pay before Blue KC begins to pay. However, every dollar applied to the individual deductible will also be applied to the family deductible. Once the family deductible is met, the plan will pay benefits for all family members.

In-Network (Participating Provider)

In-network coverage is provided for covered expenses when you receive treatment or services from a physician or hospital which is a member of the plan’s provider network. In-network coverage is the highest level of coverage provided.

Maintenance Medications

Prescription medication taken regularly to treat ongoing conditions, such as high blood pressure, high cholesterol, diabetes and asthma, are included.

Out-of-Network (Non-Participating Provider)

Out-of-Network coverage is provided for covered expenses incurred when you receive treatment or services from a physician or hospital which is not a member of the plan’s provider network. The plan considers covered expenses only up to Reasonable and Customary (R&C) limits.

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you’ll have to pay during a calendar year for covered health care services. Once you reach your out-of-pocket maximum, Blue KC begins to pay 100% of the allowed amount for covered services.

Premium

Premium is the amount of money charged for the plan you have chosen. The premium is payroll deducted from each paycheck one month prior to your coverage start date.

Reasonable and Customary

The Blue KC PPO and HDHP plans will not pay for any charge above the Reasonable and Customary (R&C) limit when you receive services from out-of-network providers, and these charges do not count towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services and supplies in your geographic area. Blue KC determines whether or not a charge is reasonable and customary and keeps up-to-date with the latest medical practices and fees around the country. Because in-network doctors and hospitals provide services and supplies for agreed-upon rates, you will never exceed R&C charges when you use in-network providers.
Routine/Preventive Services

In-network routine preventive care services and the related office visit for routine preventive care services are covered at 100% by Blue KC on all plans. Routine preventive services include, but are not limited to, annual mammogram and pap, PSA’s, colorectal cancer exams, newborn hearing screening, childhood immunizations, lead testing, physician examinations, lab work, etc. Please go online to http://benefits.lsr7.org or refer to your Blue KC contract for a detailed listing of routine preventive services.

Selecting the Right Medical Plan

There are two ways you contribute to the cost of your medical plan:

1. **Premium (Up-Front) Costs.** This is the portion of the medical insurance cost you pay. If you’re an employee, premium costs are deducted from your paycheck. If you’re retired or covered by a non-employee plan like COBRA, you write a check for the premium. Either way, you pay premium costs regularly, like any bill, no matter how often -- or how seldom -- you need health care.

2. **Pay-as-you-go Costs.** These are the out-of-pocket dollars you pay when you see a doctor, go to a hospital or outpatient clinic, or have a prescription filled. Pay-as-you-go costs include copayments, deductibles, and coinsurance. Preventive services from in-network providers have no pay-as-you-go costs.

Generally speaking, when your premium costs are higher, your pay-as-you-go costs will be lower when you receive care and vice versa.

Before choosing and enrolling in a medical plan, consider what you want and need it to do for you. Knowing what you've spent on healthcare over the past year makes it easier to choose your plan going forward.

Gather your medical expense records -- your calendar, your checkbook, receipts, and Explanation of Benefits (EOB) summaries -- to see the services you received and how much you paid in copayments, deductibles, and coinsurance. Ask yourself:

- What is your cost comfort level?
- Do you need to cover family members or just yourself?
- Do you or your family have a specific doctor or hospital you would like to or need to use?
- How often do you and your family see a doctor?
- Do you or a family member need ongoing medical care or have a chronic condition?
- How many prescription drugs do you and your family take?
- What is the true cost of the services you receive (not just the copay you are responsible for)?
- Are you covered under your spouse’s health plan or any other health plan?
- Are you paying for coverage you don’t need or use, or do you need more coverage than you have?
- How much are you paying towards the medical insurance premium through payroll deduction?

Your answers can decide the type of medical coverage that’s right for you. If you see a doctor or need prescriptions only two or three times a year, it might make more sense to pay less premium and more as-you-go. This way, you can save on premiums and avoid paying for more coverage than you might use.

To help you better understand the financial differences between the medical plan options offered by the District; please review the real-life claim examples on page 21.

Enhancing Your Medical Plan

For the 2018 plan year, the following financial savings enhancements are available:

**Basic HMO, Buy-Up HMO and PPO Enrollees:** For prescription drugs, an annual deductible of $300 per person (capped at $900 per family) will be reduced to $150 per person (capped at $450 per family). After the deductible is met regular copays apply.

**BlueSelect Plus and Preferred Care Blue HDHP Enrollees:** The plan's annual deductible of $3,150 per person (capped at $6,300 per family) will be reduced to $1,500 per person (capped at $3,000 per family). Employees enrolling in a District medical plan for the first time will automatically receive the enhanced benefits described while covered in the first plan year, therefore new enrollees do not have to meet the requirements. At the next annual open enrollment following initial enrollment in the plan, new enrollees must meet the participation requirements to continue the enhanced coverage.

In order to qualify for the 2018 above mentioned enhanced benefits, the two requirements are completion of the expanded CareHere questionnaire and a health screening by October 31, 2017.

More information can be found at http://benefits.lsr7.org/health-screenings.

Medical Plan Options

The Lee’s Summit School District plan provides you with a choice of five options: two traditional HMO’s, one traditional PPO, and two Qualified High Deductible Health Plan (HDHP) PPO. Blue Cross Blue Shield of Kansas City (Blue KC) administers all five plans. No matter which plan you choose, you may select between four levels of coverage: Employee Only, Employee & Spouse, Employee & Child(ren) or Employee & Family coverage.

If access to particular doctors and/or hospitals is important to you, you should visit www.bluekc.com to search for your preferred providers, by following the on-line instructions.

Detailed Blue KC benefit summaries can be found in this guide on pages 17-20, but following is a brief highlight of each of the Blue KC plans. Copies of the official Plan documents can be found on the Lee’s Summit School District website at http://benefits.lsr7.org.
Blue-Care HMO Plans

- With the exception of emergency situations, coverage is limited to services received within the local, Kansas City-area network of Blue Care providers. Visit www.bluekc.com to search for Blue Care providers.
- Away From Home Care is available when you or your covered dependents are temporarily residing away from home for at least 90 days. Away From Home Care is designed to address your healthcare needs if you have one of the following situations: covered children attending school out of state, covered family members residing in different HMO service areas or long-term work assignment in another state. Away from Home Care is available in many states and the District of Columbia. For more information about the Away From Home Care Program, please visit the Blue KC Website at www.bluekc.com.
- The HMO plans require you to select a Primary Care Physician (PCP) for your general care; however referrals are not required for specialist care. To find your PCP’s Blue KC identification number, please visit www.bluekc.com.
- Routine Preventive Care is covered at 100%.
- An annual eye exam benefit is included.

Buy-Up HMO:

- Office visit copays are $40 for Primary Care Physician (PCP) and $80 for specialist office visits.
- Hospital services are covered at 100% after a $400 copay per day for inpatient, and a $400 copay per occurrence for outpatient services. These copayments are limited to a combined maximum of 5 per person per year for a total of $2,000.
- Maximum out-of-pocket limit is $4,000 individual/$8,000 family. This includes all covered medical and prescription drug expenses.

Basic HMO:

- Office visit copays are $40 for Primary Care Physician (PCP) and $80 for specialist office visits.
- Hospital services are covered at 100% after a $500 copay per day for inpatient, and a $500 copay per occurrence for outpatient services. These copayments are limited to a combined maximum of 5 per person per year for a total of $2,500.
- Maximum out-of-pocket limit is $6,500 individual/$13,000 family. This includes all covered medical and prescription drug expenses.

PPO Plan:

- The PPO plan utilizes the Preferred Care Blue network of providers. You can also receive services outside of this network if desired, but you do have greater financial responsibility (see detailed Blue KC benefit summary included in this guide for details on out-of-network benefits). Through reciprocity with other Blue KC organizations around the country, the PPO plan also provides you with a national network of providers, called the Blue Card PPO. Visit www.bluekc.com to search for Preferred Care Blue providers.
- You do not need to select a Primary Care Physician (PCP).
- Routine Preventive Care is covered at 100% for network providers. Preventive Care obtained from an out-of-network provider is subject to deductible and coinsurance.
- The PPO plan does not include an eye exam benefit.
- Copays are applied to the out-of-pocket maximum.
- The office visit copay when in-network providers are used is $40.
- Out-of-network office visits are subject to the deductible of $1,000 and coinsurance of 30%.
- For in-network services, a $1,000 calendar year deductible applies to covered medical services. Deductible expense is capped at $1,000/individual and $3,000/family for those enrolled with children and/or spouse. Following the deductible, members pay 10% of remaining charges, up to an out-of-pocket maximum of $3,000 (capped at $6,000/family). Once the out-of-pocket maximum is reached, all eligible charges are paid at 100% by Blue KC for the remainder of the calendar year.
- Out-of-network services are subject to the $1,000 calendar year deductible for covered medical services. Deductible expense is capped at $1,000/individual and $3,000/family for those enrolled with children and/or spouse. Following the deductible, members pay 30% of remaining charges, up to an out-of-pocket maximum of $6,000 (capped at $12,000/family). Once the out-of-pocket maximum is reached, all eligible charges are paid at 100% by Blue KC for the remainder of the calendar year.
- The out-of-pocket maximum includes all covered medical and prescription drug expenses.
- When travelling outside the United States, The Preferred Care Blue network allows you access to providers all over the world. Services received in other countries should be for urgent or emergent issues, and will be treated as In-Network services under your PPO plan. In some cases, you may have to pay the full cost of services up front and file a claim to Blue Cross Blue Shield to apply your benefits. However, there are some providers in other countries who are considered “Preferred Providers” and those providers should charge you only your member responsibility and will file your claim on your behalf. To find out more information, locate Preferred Providers in other countries and to file claims for services received outside the US, please visit www.bcbsglobalcore.com and register today.
Prescription Drug Coverage (HMO and PPO Plans)

- For plan enhancement participants and new enrollees, a $150 per person deductible (capped at $450/family) must be met before copays apply. If enhancement requirements are not met, a $300 per person deductible (capped at $900/family) applies.
- Copays for a one-month supply of medication purchased at an Express Advantage Network (EAN) pharmacy are $15 copayment for generic drugs (Tier 1), a $40 copayment for formulary name brand drugs (Tier 2) and a $65 copayment for non-formulary name brand drugs (Tier 3).
- Copays for a one-month supply of medication purchased at a National Network pharmacy are $25 copayment for generic drugs (Tier 1), a $50 copayment for formulary name brand drugs (Tier 2) and a $75 copayment for non-formulary brand drugs (Tier 3).
- Pharmacy directories are available online. Go to www.BlueKC.com, click Find a Doctor, and scroll down to View our PDF/Print Directory.

High Deductible Health Plans (HDHP)

- The HDHP plans are PPO medical plans.
- You do not need to select a Primary Care Physician (PCP).
- The lower premium cost associated with the HDHPs allows for discretionary District contributions into the employee’s choice of a Health Savings Account or a Health Reimbursement Arrangement. Read more about Health Savings Accounts and Health Reimbursement Arrangements in this guide.
- The HDHP plans do not include office visit or prescription drug copays. Members pay negotiated cost of services until the deductible is satisfied.
- Once the deductible is reached, all eligible in-network charges will be paid at 100% by Blue KC for the remainder of the calendar year.
- Routine preventive care is the exception. These services are paid at 100% by Blue KC when a network provider is utilized. Routine preventive care obtained from an out-of-network provider is subject to the deductible and coinsurance.
- The HDHP plans do not include an eye exam benefit.

BlueSelect Plus High Deductible Health Plan

- The BlueSelect Plus High Deductible Health Plan utilizes the BlueSelect Plus network of providers. This centralized network focuses on providers in the following counties: Johnson (KS), Clay (MO), Wyandotte (MO), Jackson (MO), and Platte (MO). When you are in the greater Kansas City area, you should access providers in this network. You can also receive services outside of this network if desired, but you have greater financial responsibility (see detailed Blue KC benefit summary included in this guide for details on out-of-network benefits). If you live, or are traveling outside of the greater Kansas City area, or have kids away at college, the national Blue Card network can be utilized to receive in-network care and coverage. Visit www.bluekc.com to search for BlueSelect Plus providers.
- Blue KC has negotiated with BlueSelect Plus providers a contracted discount. Discounts average 62-64% of billed charges for medical services and 3-5% of billed charges for prescriptions.

Preferred Care Blue High Deductible Health Plan

- The Preferred Care Blue High Deductible Health Plan utilizes the Preferred Care Blue network of providers. You can also receive services outside of this network if desired, but you do have greater financial responsibility (see detailed Blue KC benefit summary included in this guide for details on out-of-network benefits). If you live, or are traveling outside of the greater Kansas City area, or have kids away at college, the national Blue Card network can be utilized to receive in-network care and coverage. Visit www.bluekc.com to search for Preferred Care Blue providers.
- Blue KC has negotiated with Preferred Care Blue providers a contracted discount. Discounts average 50% of billed charges for medical services and 3-5% of billed charges for prescriptions.
- For plan enhancement participants and new enrollees, a $3,000 calendar year deductible applies for in-network services and is further capped at $6,000/family for those enrolled with children and/or spouse. If enhancement requirements are not met, a $3,150 calendar year deductible applies and is further capped at $6,300/family. Following the deductible, all eligible in-network charges are paid at 100% by Blue KC for the remainder of the calendar year.
- For plan enhancement participants and new enrollees, a $3,000 calendar year deductible applies for out-of-network services, and is further capped at $6,000/family for those enrolled with children and/or spouse. Following the deductible, members pay 30% of remaining charges, up to an out-of-pocket maximum of $15,000 (capped at $30,000/family). If enhancement requirements are not met, a $3,150 calendar year deductible applies and is further capped at $6,300/family. Following the deductible, members pay 30% of remaining charges, up to an out-of-pocket maximum of $15,300 (capped at $30,600/family). Once the out-of-pocket maximum is reached, all eligible out-of-network charges are paid at 100% by Blue KC for the remainder of the calendar year.
- The District will contribute $205 per month ($2,460 per year) to either a Health Savings Account or Health Reimbursement Arrangement. This is money that can be used to offset your out-of-pocket costs under the plan.
Additional Blue KC Services (all medical plans)

Mail Order Prescription Program
- Blue KC utilizes Express Scripts Pharmacy for home delivery of maintenance medications.
- Home delivery from the Express Scripts Pharmacy provides an affordable way to obtain your maintenance medications, by allowing you to order up to a 102-day supply by mail. It’s the most cost effective way to fill prescriptions.
- There are three ways to start using the Express Scripts Home Delivery Pharmacy:
  1) By Phone
     - Contact the Express Scripts Patient Contact Center toll free at 1.888.218.2579.
  2) On-line
  3) By Mail
     - Ask your doctor to write a prescription for up to a 102-day supply of medication (plus refills for up to one year, if appropriate).
     - Complete a home delivery form. If you do not have a form, you can print one on-line at http://www.express-scripts.com or request one from the District’s Business Services Department at (816) 986-1048 or by email at benefits@lsr7.net.
     - Mail the completed home delivery form along with your prescription from your doctor to:
       Express Scripts
       Home Delivery Service PO Box 66538
       Saint Louis, MO 63166-9901

For additional questions regarding home delivery, please contact Express Scripts toll free at 1.888.218.2579.

Rx Savings Solutions
Using real prescription pricing and claims data, Rx Savings Solutions will notify you when you and your family can save money on your prescriptions, including finding the pharmacy in your network with the best pricing or a less expensive alternative for your current prescription. Rx Savings Solutions is available at no cost to all Blue KC members.

How to Set-Up Savings Alerts

For additional information or for questions regarding Rx Savings Solutions, please contact Blue KC at 816.395.2270 or log in to MyBlueKC.com.

Retail Telehealth
Blue KC has partnered with American Well (Amwell)* to bring you care from the comfort and convenience of your home, the office while traveling or wherever you are. Schedule and “see” a doctor online from your phone, tablet or computer using the Amwell mobile app. Telehealth is available to all Blue KC members. There is no cost for enrolling in this program and you will never pay more than $49 per visit.

How to Get Started

1: Download the Amwell Mobile App
The Amwell app can be downloaded directly to your smart phone or tablet. Or, if you prefer the web, visit Amwell.com.

2: Enroll
Create an account in a few simple steps. Be sure to include your Blue KC Insurance Information when creating your account. Your information is stored securely.

3: Choose a Doctor
View a list of available doctors, their experience and ratings, and select one.

4: Visit
Engage in a secure live video visit directly from the web or your mobile device in high-quality streaming video.

Blue KC Medical Home
As a patient of a medical home, your primary care physician will work with you to learn your health issues and causes in order to better coordinate your care.

Your physician will advise you and work directly with other healthcare specialists in your network regarding your health needs so they can assist you in managing your health.

Your physician will come to learn your entire medical history and lifestyle habits in order to better coordinate treatment with an extended care team. This comprehensive approach to patient care strengthens the patient-doctor relationship and also allows for better delivery of care.

This program is available at no cost to Blue KC members.

Steps to a Medical Home
1. Patient selects a primary care doctor.
2. Patient requests care.
3. Primary care doctor personally coordinates and manages patient care.
4. Extended care team of professionals, hospitals, nursing homes and pharmacies work together with primary care doctor to deliver treatment.
Benefits of Blue KC Medical Homes

- Coordinated access to care and prevention - Patient care is delivered in accordance with an agreed care plan between the member, his/her primary care doctor and extended care team.
- Improved patient-doctor relationship - Doctors provide one-to-one care assisting patients with healthcare needs. Your primary care doctor partners with you to ensure tests and procedures you receive are necessary and cost-effective.
- Proactive approach to patient care - Your primary care doctor lets you know when it’s time for preventive medical tests, appointments, and follow-up exams. He/she leads a team of doctors, nurses, technicians and specialists in your network to coordinate your healthcare.
- Convenient access to care - Through easier scheduling of appointments and extended office hours, members have access to healthcare advice 24 hours a day, seven days a week.
- Focused, personal interaction - Members become more informed and active in their own healthcare with their doctor and care teams who help them navigate the healthcare system.

Locating a Blue KC Medical Home primary care doctor

1. Log into MyBlueKC.com.
2. Select Find a Doctor at the top. The results from the Doctor and Hospital Provider Finder will be tailored to show medical home providers in your specific Blue KC network.
3. Expand Add Filter then select Recognitions and choose Patient Centered Medical Home.
4. Complete the search form and select Go.

Personal Medication Coach

A Personal Medication Coach is available at no cost to all Blue KC members who see a Patient-Centered Medical Home Provider. Members who take multiple medications for at least two chronic health conditions (asthma/COPD, chronic pain, depression, diabetes, heart failure, hepatitis C, high blood pressure, high cholesterol, HIV, osteoporosis or oncology) will be able to speak directly with a Personal Medication Coach (a registered pharmacist or licensed pharmacy intern).

The Personal Medication Coach will provide members with a full assessment of current medications, identify unsafe drug interactions, review over-the-counter medications and supplements, discuss alternative lower-cost medications and answer medication-related questions.

Members who qualify for the program will be contacted directly by Blue KC. For additional information or for questions regarding this program, please contact Blue KC at 816.395.2270.
Medical Plan Costs

Depending on which plan you choose, the monthly cost for your 2018 coverage will be as follows for full-time staff. For part-time costs, please contact the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

The premiums will be deducted from your paycheck one month prior to the coverage effective date. HSA and HRA contributions will be made in the month your coverage begins.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Total Cost</th>
<th>Paid by District</th>
<th>Your Cost</th>
<th>District HSA or HRA Contribution</th>
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<tbody>
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<td><strong>BlueSelect Plus High Deductible</strong></td>
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</table>

*"Special Family" refers to families with child(ren), in which both spouses are employed by LSR7. On the HDHPs, it may be financially more advantageous for the family to enroll in a Blue KC Family plan because of the annual deductible. Special Families receive the full District premium contribution, as well as the full HSA/HRA contribution. Enrolling as a special family limits the annual in-network deductible.
HMO Medical Plan Option Summaries

The HMO plans are traditional plan offerings with copays for services such as doctor’s office visits and prescription drugs. This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to the Certificate of Coverage (COC) for a complete plan description and specific limitations. If a conflict arises, the COC will govern in all cases. The COC can be found on the District’s website at: http://benefits.lsr7.org or can be obtained by contacting Blue KC member services at 816. 395.3558.

<table>
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<tr>
<th>Benefit Highlights</th>
<th>Buy-Up HMO</th>
<th>Basic HMO</th>
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</thead>
<tbody>
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<td><strong>Annual Deductible</strong></td>
<td>Individual: N/A</td>
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</tr>
<tr>
<td></td>
<td>Family: N/A</td>
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<td><strong>Coinsurance (Plan Pays)</strong></td>
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<td>Family: $8,000</td>
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<td>Specialist Physician Office Visit</td>
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<td>Lab Performed in Physician’s Office</td>
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<td><strong>Routine Preventive Care (contract lists covered services)</strong></td>
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<td>Age/Gender Recommended Screenings</td>
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<tr>
<td><strong>Emergency &amp; Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$80 Copay</td>
<td>$80 Copay</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>$200 Copay</td>
<td>$200 Copay</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization / Outpatient Surgical Care</strong></td>
<td>$400 Copay per Day up to $2,000 per Member</td>
<td>$500 Copay per Day up to $2,500 per Member</td>
</tr>
<tr>
<td><strong>Outpatient Non-Surgical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI, MRA, CT and PET Scans</td>
<td>$200 Copay</td>
<td>$200 Copay</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Speech &amp; Hearing Therapy</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>$40 Copay</td>
<td>$40 Copay</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Manipulations</td>
<td>Manipulations $40</td>
<td>Manipulations $40</td>
</tr>
<tr>
<td><strong>Prescription Drug Deductible (2)</strong></td>
<td>$150 ($450/Family Max)</td>
<td>$150 ($450/Family Max)</td>
</tr>
<tr>
<td><strong>Retail Rx Copays (34-Day Supply)</strong></td>
<td>EAN</td>
<td>National</td>
</tr>
<tr>
<td>Generic (Tier 1)</td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>Formulary Name Brand (Tier 2)</td>
<td>$40</td>
<td>$50</td>
</tr>
<tr>
<td>Non-Formulary Name Brand (Tier 3)</td>
<td>$65</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Mail Order Copays (102-Day Supply)</strong></td>
<td>2x EAN Retail Copay</td>
<td>2x EAN Retail Copay</td>
</tr>
</tbody>
</table>

1. Total of all covered medical and prescription drug expenses.
2. When enhancement requirements are not met, the Prescription Drug Deductible increases to $300 ($900/Family Maximum). Benefit limitations may apply.
The Preferred Care Blue Qualified High Deductible Health Plan (HDHP) plan, requires special consideration, but can be advantageous to both low and high utilizers of health services. This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to the Certificate of Coverage (COC) for a complete plan description and specific limitations. If a conflict arises, the COC will govern in all cases. The COC can be found on the District’s website at: [http://benefits.lsr7.org](http://benefits.lsr7.org) or can be obtained by contacting Blue KC member services at (816) 395-3558.

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>Preferred Care Blue HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Annual Deductible (1)</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Coinsurance (Plan Pays)</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (1)</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Physician Services</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office Visit</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Lab Performed in Physician’s Office</td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Routine Preventive Care (contract lists covered services)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Mammograms, Pap Smear &amp; PSA</td>
<td>100%</td>
</tr>
<tr>
<td>Age/Gender Recommended Screenings</td>
<td>100%</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emergency &amp; Urgent Care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inpatient Hospitalization / Outpatient Surgical Care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient Non-Surgical Care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI, MRA, CT and PET Scans</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Speech &amp; Hearing Therapy</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Retail Pharmacy (34-Day Supply)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Tier 1)</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Formulary Name Brand (Tier 2)</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Non-Formulary Name Brand (Tier 3)</td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

| **Mail Order Pharmacy (102-Day Supply)** | N/A |

1. When enhancement requirements are not met, the Medical Plan Deductible and Out-of-Pocket Maximum increases to $3,150 ($6,300/Family) in-network and out-of-pocket maximum $6,300 ($12,600/Family) out-of-network. Benefit limitations may apply.
BlueSelect Plus Qualified High Deductible Health Medical Plan Option Summary

The BlueSelect Plus Qualified High Deductible Health Plan (HDHP) plan requires special consideration, but can be advantageous to both low and high utilizers of health services. This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to the Certificate of Coverage (COC) for a complete plan description and specific limitations. If a conflict arises, the COC will govern in all cases. The COC can be found on the District’s website at: http://benefits.lsr7.org or can be obtained by contacting Blue KC member services at (816) 395-3558.

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>BlueSelect Plus HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Annual Deductible (1)</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance (Plan Pays)</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (2)</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Specialist Physician Office Visit</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Lab Performed in Physician's Office</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td><strong>Routine Preventive Care (contract lists covered services)</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Mammograms, Pap Smear &amp; PSA</td>
<td>100%</td>
</tr>
<tr>
<td>Age/Gender Recommended Screenings</td>
<td>100%</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Emergency &amp; Urgent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization / Outpatient Surgical Care</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Non-Surgical Care</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>MRI, MRA, CT and PET Scans</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Speech &amp; Hearing Therapy</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td><strong>Retail Pharmacy (34-Day Supply)</strong></td>
<td></td>
</tr>
<tr>
<td>Generic (Tier 1)</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Formulary Name Brand (Tier 2)</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Non-Formulary Name Brand (Tier 3)</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy (102-Day Supply)</strong></td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

1. When enhancement requirements are not met, the Medical Plan Deductible increases to $3,150 ($6,300/Family). Benefit limitations may apply.
2. When enhancement requirements are not met, the medical out-of-pocket maximum increases to $3,150 ($6,300/Family) in-network and $15,300 ($30,600/Family) out-of-network. Benefit limitations may apply.
PPO Medical Plan Option Summary

The PPO plan is a traditional plan offering with copays for services such as doctor’s office visits, prescription drugs and annual deductible. This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to the Certificate of Coverage (COC) for a complete plan description and specific limitations. If a conflict arises, the COC will govern in all cases. The COC can be found on the District’s website at: http://benefits.lsr7.org or can be obtained by contacting Blue KC member services at 816. 395.3558.

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>PPO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Coinsurance (Plan Pays)</strong></td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (1)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>$40 Copay</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Specialist Physician Office Visit Lab</td>
<td>$80 Copay</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Performed in Physician’s Office</td>
<td>No Copay</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td><strong>Routine Preventive Care (contract lists covered services)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>100%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Mammograms, Pap Smear &amp; PSA</td>
<td>100%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Age/Gender Recommended Screenings</td>
<td>100%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>100%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency &amp; Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$80 Copay</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>$200 Copay, then Deductible, then 90%</td>
<td>$200 Copay, then Deductible, then 90%</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization / Outpatient Surgical Care</strong></td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td><strong>Outpatient Non-Surgical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI, MRA, CT and PET Scans</td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy</td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Speech &amp; Hearing Therapy</td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>Deductible, then 90%</td>
<td>Deductible, then 70%</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Office Visit $80; Manipulations: Deductible, then 90%</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Deductible (2)</strong></td>
<td>$150 ($450/Family Maximum)</td>
<td></td>
</tr>
<tr>
<td>Retail Rx Copays (34-Day Supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic (Tier 1)</td>
<td>EAN</td>
<td>National</td>
</tr>
<tr>
<td>Formulary Name Brand (Tier 2)</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td>Non-Formulary Name Brand (Tier 3)</td>
<td>$75</td>
<td></td>
</tr>
<tr>
<td>Mail Order Copays (102-Day Supply)</td>
<td>2x EAN Retail Copay</td>
<td>2x EAN Retail Copay</td>
</tr>
</tbody>
</table>

1. Total of all covered medical and prescription drug expenses.
2. When enhancement requirements are not met, the Prescription Drug Deductible increases to $300 ($900/Family Maximum). Benefit limitations may apply.
Your Medical Plans in Action

To help you better understand the monetary differences between the plan options, review the following scenarios. Consider your own personal situation in a similar manner to help you make an informed decision, and choose the most affordable health plan that best meets your needs. For simplicity, each of the examples assumes you have used in-network providers, and you have met the enhanced programming requirements. Remember, these are just illustrations and are not intended to fit every situation.

Example #1 - Low Utilizer Annual Cost

George is in good health with employee coverage. He has a preventive exam & lab services, one diagnostic office visit, one tier-1 prescription taken monthly, and one tier-2 prescription filled in June.

<table>
<thead>
<tr>
<th>Claims</th>
<th>Basic HMO</th>
<th>Buy-Up HMO</th>
<th>PPO</th>
<th>Preferred Care Blue</th>
<th>Blue Select Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Premium (Employees Share)</td>
<td>$480</td>
<td>$912</td>
<td>$1,764</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PCP Diagnostic Exam (One)</td>
<td>$125</td>
<td>$40</td>
<td>$40</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Tier-1 Generic Rx (Taken Monthly)</td>
<td>$255</td>
<td>$325</td>
<td>$255</td>
<td>$325</td>
<td>$360</td>
</tr>
<tr>
<td>Tier-2 Brand Name Rx (Taken Once)</td>
<td>$40</td>
<td>$50</td>
<td>$40</td>
<td>$50</td>
<td>$132</td>
</tr>
<tr>
<td>Less District HSA/HRA Contribution</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Employee Annual Cost</strong></td>
<td>$815</td>
<td>$895</td>
<td>$1,247</td>
<td>$2,099</td>
<td>($1,279)</td>
</tr>
</tbody>
</table>

Example #2 - High Utilizer Annual Cost

Jon has a chronic condition and has employee only coverage. He has a preventive exam, tier-1 and tier-2 prescriptions filled monthly, four diagnostic specialist office visits, and a 5 day inpatient hospital stay.

<table>
<thead>
<tr>
<th>Claims</th>
<th>Basic HMO</th>
<th>Buy-Up HMO</th>
<th>PPO</th>
<th>Preferred Care Blue</th>
<th>Blue Select Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Premium (Employees Share)</td>
<td>$480</td>
<td>$912</td>
<td>$1,764</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Hospital (5 Days)</td>
<td>$2,500</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Preventive Exam</td>
<td>$75</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist Diagnostic Exam (Four)</td>
<td>$175</td>
<td>$320</td>
<td>$320</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier-1 Generic Rx (Taken Monthly)</td>
<td>$315</td>
<td>$425</td>
<td>$315</td>
<td>$425</td>
<td>$0</td>
</tr>
<tr>
<td>Tier-2 Brand Name Rx (Taken Monthly)</td>
<td>$85</td>
<td>$600</td>
<td>$480</td>
<td>$600</td>
<td>$0</td>
</tr>
<tr>
<td>Less District HSA/HRA Contribution</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>($1,896)</td>
</tr>
<tr>
<td><strong>Total Employee Annual Cost</strong></td>
<td>$4,095</td>
<td>$4,325</td>
<td>$4,257</td>
<td>$4,764</td>
<td>($2,460)</td>
</tr>
</tbody>
</table>

Now that you’ve considered your health care and coverage needs, think about which type of plan might be best for you. There is no right or wrong choice. The plan you choose should simply be the one you’re most comfortable with – a plan that fits your health needs, budget, and personal preferences. No matter which plan you enroll in, you’ll have the assurance of financial protection against any major, unexpected medical expenses which are covered by your plan.
Health Savings Account (For HDHP Enrolees Only)

Per IRS regulations, you must be covered by a Qualified High Deductible Health Plan, such as the District's Blue Saver HDHP, in order to make or receive contributions to a Health Savings Account (HSA). HDHP PPO enrollees may be eligible to open a Health Savings Account (HSA) into which the District's contribution will be deposited. Health Savings Accounts have a number of features which make them very attractive, but not everyone is eligible to open or contribute to an HSA.

You are NOT eligible to make or receive contributions to an HSA if:

- You can be claimed as a dependent on someone else’s tax return, OR
- You have other medical insurance coverage which is a traditional medical plan or any other non-Qualified medical plan, OR
- You have medical coverage provided by TriCare, Medicare or Medicaid, OR
- You have been in receipt of non-preventive care benefits from the Department of Veteran’s Affairs (VA) or one of its facilities, including prescription drugs, in the prior 3-month period, you are excluded from contributing or receiving contributions the next 3 months (NOTE: Hospital care or medical services for a service connected disability will not affect your HAS eligibility), OR
- You or your spouse participate in a Section 125 Medical Flexible Spending Account (FSA). You are considered to be a “beneficiary” of your spouse’s Medical FSA even if you do not plan to run your expenses through it. (NOTE: There is no restriction to participating in a Section 125 Dependent Care Account, Limited Flexible Spending Account or sheltering premium payments for medical, dental, vision, and life insurance.), OR
- You or your spouse are covered under a Health Reimbursement Arrangement.

If you are enrolled in a District Health Reimbursement Arrangement (HRA) or Section 125 Medical Flexible Spending Account (FSA- Medical) for 2017 and enrolling a Health Savings Account (HSA) for 2018, funds remaining in your FSA as of December 31, 2017 will be forfeited and funds remaining in your HRA as of December 31, 2017 maybe eligible to be suspended and used for eligible dental and/or vision expenses. There are specific IRS regulations when FSA/ HRA participants enroll in an HSA. For additional information, please contact the District’s Benefits Coordinator (816) 986-1048.

If one or more of the above restrictions disqualifies you from opening up a Health Savings Account, the District contribution will made to the Health Reimbursement Arrangement instead. If you open and contribute to an HSA and then later become ineligible, you will simply be restricted from making and/ or receiving additional contributions while ineligible, you will need to complete an “Insurance Change Form”. This form can be found in the Forms section of Employee Online or in the Business Services Department at Stansberry Leadership Center.

You will be able to continue to access accumulated funds in your HSA to pay for eligible expenses until your HSA is depleted.

Health Savings Account Features

Health Savings Accounts work much like an IRA: the money belongs to you, unused balances roll over year-to-year, the account moves with you from employer-to-employer, and funds can be used to pay for healthcare costs in your retirement. There is no “use it or lose it” requirement such as applies to Section 125 Medical Flexible Spending Accounts.

Contributions into an HSA are tax-free, but are limited by IRS requirements. For 2018 the limit is $3,450 for those enrolled in a Qualified HDHP as individuals, and $6,900 for those enrolled with dependents. The limit of $6,900 is per family therefore, if both spouses contribute to their respective HSAs, they cannot exceed combined contribution of $6,900. The annual contribution the District makes on your behalf must be included in these limits. If you’re age 55 or older, you may make an additional $1,000 “catch-up” contribution. All limits are indexed by the IRS annually. You also have the opportunity to add additional money to your HSA through a pre-tax payroll deduction.

You will receive a debit card and checks from Central Bank of the Midwest, the District’s HSA vendor, for your HSA. Withdrawals from your HSA account are always tax-free when used to pay for qualified medical expenses. Funds withdrawn for non-qualified expenses are subject to a 20% penalty and regular taxation; however, the 20% penalty is waived upon attainment of age 65. Funds may be withdrawn from an HSA only as they are deposited; in other words, you cannot “borrow ahead” on future contributions, but you can pay yourself back with tax-free dollars at a later date.

Documentation of your expenses is not required with requests for withdrawal, but you must maintain receipts in case of audit by the IRS. The account belongs to you, and proper use of HSA funds is your sole responsibility.

Your HSA contributions are initially deposited into an interest-bearing, FDIC-insured account at Central Bank of the Midwest. The FDIC-insured feature rewards you with graduating rates of interest as the balance in your Health Savings Account grows.

Central Bank of the Midwest offers the option to direct funds into preselected investments. The minimum investment amount is $500. Central Bank of the Midwest has agreed to waive the annual fee for invested HSA accounts for District employees with an HSA.

A financial advisor with Central Bank of the Midwest is available to assist you in establishing an HSA investment account and provide you with additional information. A Central Bank of the Midwest financial advisor can be reached at (816) 224-7220 and is located at the Central Bank of the Midwest Branch at 609 North 291 Highway. Information can also be found at www.centralinvestment.net.
Health Savings Account Eligible Expenses

Expenses eligible for tax-free reimbursement through an HSA are defined by IRS Publication 502 and are available on-line at www.irs.gov. Generally, any medical, dental and vision care expense which is considered tax deductible can be paid through your HSA. You can use your HSA to pay expenses for you, your spouse and your eligible children, even if they are not enrolled in a Lee’s Summit School District’s HDHP. For a brief listing of the most common eligible expenses, please see page 54.

Health Savings Accounts have the added advantage of allowing additional expenses that are ineligible under a Section 125 Medical FSA:

• Post-age 65 retiree health insurance premium (Pre-age 65 retiree premiums are not eligible).
• Premium for Medicare Parts A & B (Medicare supplement plan premiums are not eligible).
• COBRA premium.
• Health insurance premium if you are receiving unemployment.
• Premium for certain Long Term Care policies (the premium for the Lee’s Summit R-7 UNUM Long Term Care plan is not eligible, but an individually purchased policy may be).

How to Open a Health Savings Account

The District will make contributions only to Central Bank of the Midwest HSA account holders. To open your HSA on-line, please follow these directions:

1. Go to www.centralbank.net
2. Select “Open An Account”
3. Select “Midwest”
4. Select “Health Savings Account Open Now”
5. Enter the following Offer Code: HSA9868900 (leave the referral code blank), confirm Security Check and click “Continue to Application”
6. Follow the on-line instructions to set up your account
7. Central Bank of the Midwest may also require 2 forms of photocopy identification (e.g. driver’s license, employee ID badge, social security card, etc.). You will receive a Welcome Packet from Central Bank of the Midwest and at that time you may be asked to provide this information. You will receive a debit card in the mail from Central Bank of the Midwest.

If you are unable to open your account on-line, you may visit any Central Bank of the Midwest location or request an enrollment packet from the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

Health Reimbursement Arrangement (For HDHP Enrollees Only)

HDHP PPO enrollees not eligible for a Health Savings Account (HSA) will have the District’s contribution deposited into a Health Reimbursement Arrangement (HRA). Your HRA account will include only District contributed funds.

Health Reimbursement Arrangement Features

• Contributions into an HRA are tax-free as long as you use the funds for qualified expenses.
• HRA funds can be used to pay for qualified expenses for you and your spouse and children only if they are enrolled in the District HDHP medical plan with you.
• Funds will be added to your account each payday.
• Funds must be deposited into the HRA account before you can use them.
• A list of the most common eligible expenses can be found on page 54.
• You can request reimbursement for eligible expenses incurred from the date you begin participating in the HDHP through December 31, 2018.
• Balance in the HRA account on December 31, 2018 may be able to roll-over to 2019. Roll-over funds in the HRA account can accumulate to a maximum of $4,999.
• You will receive a debit card in the mail from Surency Life and Health, the District’s HRA provider.
• You are not required to use the debit card to pay expenses. You can request reimbursement through your on-line account or print a claim form to email, fax or mail to Surency.
• If you terminate employment with the District, you will be able to submit claims for reimbursement through the end of the plan year in which you terminate for services provided during the plan year.
• If you are enrolled in a Health Reimbursement Arrangement (HRA) for 2017 and enroll in a Health Savings Account (HSA) for 2018, the funds remaining in your HRA as of December 31, 2017 may be eligible to be suspended and used for eligible dental and/or vision expenses. There are specific IRS regulations when HRA participants enroll in an HSA. For additional information, please contact the District’s Benefits Coordinator at (816) 986-1048.
• Upon enrollment into a HRA, you will receive an enrollment packet which will contain additional information.
Dental Insurance

Good dental health is critical to your overall health. The Lee’s Summit School District dental plan is flexible enough to respond to a variety of dental care needs. Whether you need a check-up, a filling, or major dental work, the dental plan covers you.

Terminology

Before you read further about your dental benefit choices, there are some terms you will need to understand.

Annual Maximum

For all services, other than orthodontia, there is a maximum benefit, which Cigna will pay each calendar year per individual. Once this maximum is reached, no further benefits will be payable during the calendar year. The amount of the annual maximum depends on the plan you choose.

Coinsurance

You and Cigna share in the payment of your dental bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers were utilized.

Lifetime Maximum

For orthodontics there is a maximum benefit that Cigna will pay for each individual. Once this maximum is reached, no further benefits will be payable.

Orthodontics

These services involve the movement of teeth with orthodontic appliances to correct imperfect position or abnormal bite. Cosmetic orthodontics are not covered. Orthodontic services are covered for both adults and dependent children covered by the plan.

Non-Network Reimbursement

For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursement Charge. The MRC is calculated at the 90th percentile of all provider charges in the geographic area. The dentist may balance bill pay to their usual fees.

Dental Plan Options

The Lee’s Summit School District plan provides you with two choices when it comes to your dental coverage -- the Base Plan or the Buy-Up Plan. Cigna administers both dental plans. Copies of the official Plan documents can be found on the Lee’s Summit School District website at http://benefits.lsr7.org.

A network of participating dentists is available to you through the Cigna DPPO network. If you choose to see a dentist who participates in this network, you will realize a cost savings. Participating dentists cannot bill you for any charges which are in excess of Cigna’s fee schedule, and they have discounted the fees that they do charge. In addition, participating dentists will file your claims directly with Cigna eliminating the need for you to deal with any paperwork.

Should you choose not to see a participating dentist, your benefits may be reduced. Additionally, a non-participating dentist can bill you for any charges which are in excess of Cigna’s allowable amount and may require you to pay for your entire services up front, leaving you to file a claim for reimbursement directly with Cigna.

To obtain a list of dentists participating in the Cigna DPPO network, go to https://www.cigna.com/hcpdirectory/. Click “Find a Doctor,” Click on “Dentist” enter your zip code, select a plan, click “Dental Plan”, select “Cigna Dental PPO/EPO”, click “Choose”.

Depending on which plan you choose, the monthly cost for your 2018 coverage will be as follows. The premiums will be deducted from your paycheck one month prior to the coverage effective date.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Total Cost</th>
<th>Paid by District</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$18.62</td>
<td>$18.82</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$37.66</td>
<td>$18.82</td>
<td>$18.84</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$51.60</td>
<td>$18.82</td>
<td>$32.78</td>
</tr>
<tr>
<td>Full Family</td>
<td>$69.68</td>
<td>$18.82</td>
<td>$50.86</td>
</tr>
<tr>
<td>Buy-Up Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$35.54</td>
<td>$18.82</td>
<td>$16.72</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$70.40</td>
<td>$18.82</td>
<td>$51.58</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$96.72</td>
<td>$18.82</td>
<td>$79.90</td>
</tr>
<tr>
<td>Full Family</td>
<td>$131.58</td>
<td>$18.82</td>
<td>$112.76</td>
</tr>
</tbody>
</table>
# Base Dental Plan Option Summary

<table>
<thead>
<tr>
<th>Cigna Dental DPPO Plan Features</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Diagnostic and Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exams, two per calendar year</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Bitewing x-rays, two per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full-mouth x-rays, once in any 36 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prophylaxis (cleaning &amp; scaling), twice per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extra cleaning with certain health conditions*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Topical fluoride application to age 19, once per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sealants: Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space maintainers limited to non-orthodontic treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Basic Services</strong></td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>• Restorative: fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endodontics: minor and major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontics: minor and major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral Surgery: minor and major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia: general and IV sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repairs: Bridges, Crowns and Inlays, replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repairs: Dentures, reviewed if more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Denture Relines, Rebases and Adjustments, covered if more than 6 months after installation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Care to Relieve Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crowns: prefabricated stainless steel / resin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Individual Deductible Per Calendar Year | None |
| Calendar Year Benefit Maximum/Progressive Maximum Benefit | Year 1: $500; Year 2: $750; Year 3: $1,000; Year 4: $1,250 |
| Increase contingent upon receiving Preventive Services in previous plan years |

*Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There’s no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.

Dependent Age Limit: End of calendar year in which your dependent turns 26.

This is intended to be a summary only. Please refer to your Summary Plan description (SPD) for a more complete listing of services including plan limitations and exclusions. Should discrepancies arise, the SPD will govern.
## Buy-Up Dental Plan Option Summary

<table>
<thead>
<tr>
<th>Cigna Dental DPPO Plan Features</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Diagnostic and Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams, two per calendar year</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Bitewing x-rays, two per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-mouth x-rays, once in any 36 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleaning &amp; scaling), twice per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra cleaning with certain health conditions*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical fluoride application to age 19, once per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space maintainers limited to non-orthodontic treatment for children under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care to Relieve Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cigna DPPO Dentist</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cigna Non-Participating Dentist</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Basic Services</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Restorative: fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics: minor and major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics: minor and major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: simple extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Extraction of Impacted Teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia: general and IV sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs: Bridges, Crowns and Inlays, replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs: Dentures, reviewed if more than once</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture Relines, Rebases and Adjustments, covered if more than 6 months after installation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants: per tooth; limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns: prefabricated stainless steel / resin</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Major Services</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays and Onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthesis Over Implant, one every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns: permanent case and porcelain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridges and Dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: all except simple extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Orthodontic Services</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Coverage for adults and children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Individual Deductible Per Calendar Year

| None |

### Calendar Year Benefit Maximum/Progressive Maximum Benefit

| Year 1: $1,000; Year 2: $1,250; Year 3: $1,500; Year 4: $1,750 Increase contingent upon receiving Preventive Services in previous plan years |

### Lifetime Orthodontia Maximum (Separate)

| $1,000 |

*Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There’s no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.

**Dependent Age Limit:** End of calendar year in which your dependent turns 26.

This is intended to be a summary only. Please refer to your Summary Plan description (SPD) for a more complete listing of services including plan limitations and exclusions. Should discrepancies arise, the SPD will govern.
Vision Insurance

The Lee’s Summit School District offers a comprehensive, voluntary vision plan through Vision Service Plan (VSP).

For those employees who choose not to enroll in one of the VSP plans described below, the District provides you and your eligible dependents with a discount plan, called the “Access Plan”, through VSP at no cost to you. This plan provides a 15-20% discount on eye exams, contact lens exams and prescription eyewear (lenses and frames) obtained from a participating VSP provider.

To obtain a list of providers participating in the VSP network, go to www.vsp.com. You are automatically enrolled in this plan at no cost as long as you are not enrolled in one of the more comprehensive, voluntary VSP plans described below.


Through the more comprehensive VSP Choice plans, you will have coverage for routine eye exams, materials (including eyeglasses and contact lenses) and laser vision correction. You are free to see any provider you wish; however, you will receive a higher level of benefits should you receive your care from a participating VSP provider. To obtain a list of providers participating in the VSP network, go to www.vsp.com. The District offers two comprehensive plans: the Basic Plan and the Buy-Up Plan.

The monthly cost for your 2018 coverage will be as follows. The premiums will be deducted from your paycheck one month prior to the coverage effective date.

<table>
<thead>
<tr>
<th>Vision</th>
<th>Basic Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$11.88</td>
<td>$18.96</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$18.64</td>
<td>$29.74</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$18.38</td>
<td>$29.34</td>
</tr>
<tr>
<td>Full Family</td>
<td>$29.64</td>
<td>$47.30</td>
</tr>
</tbody>
</table>
# Vision Plan Option Summaries

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Basic Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Exam</td>
<td>Every 12 Months</td>
<td>Every 12 Months</td>
</tr>
<tr>
<td>Lenses</td>
<td>Every 12 Months</td>
<td>Every 12 Months</td>
</tr>
<tr>
<td>Frames</td>
<td>Every 24 Months</td>
<td>Every 12 Months</td>
</tr>
<tr>
<td><strong>Member Copayment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Materials</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Basic Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in full after copay</td>
<td>Covered in full after copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in full after copay</td>
<td>Covered in full after copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in full after copay</td>
<td>Covered in full after copay</td>
</tr>
<tr>
<td>Progressives/Blended</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td>Bifocal Anti-Reflective Coating</td>
<td>Discount Only</td>
<td>Covered in full after copay</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail</td>
<td>$130 allowance, plus 20% off remaining balance</td>
<td>$150 allowance, plus 20% off remaining balance</td>
</tr>
<tr>
<td>Featured Frame</td>
<td>$180 allowance, plus 20% off excess</td>
<td>$200 allowance, plus 20% off excess</td>
</tr>
<tr>
<td><strong>Contact Lens Fitting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Contact Lenses</td>
<td>$130 allowance for contacts when contacts are selected in lieu of eyeglasses, you will be eligible for eyeglasses 12 months from date of purchase</td>
<td>$150 allowance for contacts; when contacts are selected in lieu of eyeglasses, you will be eligible for eyeglasses 12 months from date of purchase</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Out-of-Network Benefits</th>
<th>Basic Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam</td>
<td>Up to $45</td>
<td>Up to $45</td>
</tr>
<tr>
<td><strong>Basic Lenses</strong></td>
<td></td>
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</tr>
<tr>
<td>Single Vision</td>
<td>Up to $30</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Up to $50</td>
<td>Up to $50</td>
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<tr>
<td>Trifocal</td>
<td>Up to $65</td>
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<tr>
<td><strong>Frames</strong></td>
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<tr>
<td></td>
<td>Up to $70</td>
<td>Up to $70</td>
</tr>
<tr>
<td><strong>Prescription Contact Lenses &amp; Fitting Exam</strong></td>
<td>Up to $105</td>
<td>Up to $105</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discounts</th>
<th>Basic Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Covered Lens Options</td>
<td>Average 20% - 25%</td>
<td>Average 20% - 25%</td>
</tr>
<tr>
<td>Additional Glasses or Sunglasses</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Contact Lens Exam</td>
<td>15% off cost of fitting &amp; evaluation</td>
<td>15% off cost of fitting &amp; evaluation</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>Average 15% off regular price, or 5% off Promotional price</td>
<td>Average 15% off regular price, or 5% off promotional price</td>
</tr>
</tbody>
</table>

This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to your Certificate of Coverage (COC) for a complete plan description. If a conflict arises, the COC will govern in all cases.
Section 125 Plan

There are some expenses you know you will have to pay in the coming year: premiums for Lee’s Summit School District sponsored benefits; out-of-pocket expenses not covered by the medical, dental or vision plans; or care for a child while you are at work. You normally pay these costs with after-tax income. However, the Lee’s Summit School District Section 125 (governed by the IRS) plan lets you use your pretax dollars to pay for eligible premiums and out-of-pocket health and dependent care expenses. The result is that you pay less in taxes and increase your take home pay.

Tax Sheltered Premium Payments

The Section 125 plan allows you to pay for some of your District-sponsored benefits with pre-tax dollars. If you and any of your dependents are covered by the District’s medical, dental, vision and/ or employee supplemental life plans, the portion of the premium you pay may be deducted pre-tax. This allows you to reduce your pay before taxes and increases your take home pay. The costs of your insurance are paid directly to the insurance company requiring no additional paperwork from you. You may make this election during your on-line enrollment process.

Flexible Spending Accounts (FSA)

The Section 125 plan also lets you redirect a portion of your pay, through the convenience of payroll deduction, to create a spending account for healthcare and/or dependent care expenses. The money that goes into your spending account(s) is deducted on a pre-tax basis. This means that the money is deducted from your pay before federal, state and social security taxes are calculated. Because you do not pay these taxes on money that goes into your spending accounts, you decrease your taxable income and increase your take home pay.

In estimating your election amounts for the medical, limited and/or dependent care accounts, remember all expenses must be incurred between January 1, 2018 and December 31, 2018.* Estimate conservatively, as unused funds at the end of the plan year are forfeited. To help estimate your annual FSA election, please use the “Election Worksheet” on page 55. Medical and Dependent Care amounts are not “transferable” between accounts. After January 1, 2018, you cannot change your elections unless you have a qualifying change in family status. For a complete description of the plan, refer to the Flexible Spending Account Plan document available on the District’s website at http://benefits.lsr7.org. Or, you can obtain a copy from the Business Services Department.

How much money should you put into your spending account? That depends on your expenses. We recommend you review eligible expenses for the last few years to predict your expenses for 2018. During your enrollment, you’ll elect an annual contribution amount which will then be deducted from your paycheck in equal monthly installments. You file claims for reimbursement as eligible expenses are incurred from the money that accumulates in each account.

For instructions on how to request and receive reimbursement of your eligible expenses, please see the section titled “Requesting Reimbursement from Section 125 FSA Spending Accounts” on page 31.

Consider how much to put aside carefully:

- Once you make your choices, your contributions will remain unchanged unless you experience a qualifying change in family status. The changes you request must be consistent with the status change event. Examples of qualifying status changes include:
  - Marriage.
  - Divorce, legal separation or annulment.
  - Birth or adoption of your child.
  - Death of your spouse or child.
  - Change in your or your spouse’s employment status.
  - Change in your number of tax dependents.
  - Change in your dependent’s eligibility (for example, your child reaches age 13) where he/she is no longer eligible under a Dependent Care Account.
  - Change in your child care/elder care provider or cost of coverage, such as a significant cost increase charged by your current day care provider, or a change in your day care provider. This applies to a Dependent Care Account only.

- You can use the money in your reimbursement accounts only for expenses incurred in 2018.
- Internal Revenue Service regulations prevent unused money in your accounts from being returned to you; any unused amounts are forfeited (i.e., “use it or lose it”).
- As you plan, it is also important to remember your health care and dependent care spending accounts are separate. You cannot transfer money from one account to the other.

*For newly hired employees, your elections should be calculated based on your anticipated expenses from your hire date through the end of 2018. To determine your monthly contribution amount, divide your anticipated expenses by the number of months remaining in 2018.

Medical Flexible Spending Account

HSA participants are NOT eligible for the Medical Flexible Spending Account but may establish a Limited FSA (see page 30)

The Medical FSA helps you pay for eligible health care expenses not paid by insurance; it does not replace an insurance plan, but it can help you get more for your money by using pre-tax dollars on out-of-pocket health care services. The IRS limits how much you can contribute each year.

The IRS limit is per person and not per family. Therefore, if a husband and wife both participate in their respective employer’s FSA plans, each cannot contribute more than the individual IRS limit.
Medical Flexible Spending Account (Con’t)

Generally, any health expense (except for cosmetic procedures and insurance premiums) considered tax deductible can be paid through your medical spending account. You can use your medical spending account to pay expenses for you, your spouse, and your eligible children, even if they are not enrolled in a Lee’s Summit School District medical plan.

You can file claims for any amount up to your total annual contribution amount at any time during the year, even if you have not yet had that amount withheld from your pay. You will receive a reimbursement for your entire claim. You will continue to make your contributions each paycheck to cover the claim. For a brief listing of the most common eligible expenses, please see page 54.

If you are enrolled in a Section 125 Medical Flexible Spending Account (FSA-Medical) for 2017 and enroll in a Health Savings Account (HSA) for 2018, you must have a $0 balance in your FSA as of December 31, 2017. If a balance remains, it will be forfeited. There are specific IRS regulations when FSA participants enroll in an HSA. For additional information, please contact the District’s Benefits Coordinator at (816) 986-1048.

Limited Flexible Spending Account

(ONLY for HDHP PPO Enrollees with HSA)

HDHP PPO enrollees who contribute to a Health Savings Account (HSA) are ineligible to contribute to a regular Medical FSA, but do have the option of enrolling in a Limited FSA. The Limited FSA allows reimbursement of you and your dependents’ dental and vision expenses only.

You can always run your dental and vision expenses (ex: orthodontics, Lasik, etc.) through your HSA, but you may choose to open a Limited FSA in order to maximize the savings potential of your HSA, or if you or your dependents have dental and/or vision expenses which exceed the amount you are allowed to contribute to an HSA.

Like the regular Medical FSA, the IRS limits how much you can contribute each year. Estimate conservatively as unused funds at the end of the plan year are forfeited.

Dependent Care Flexible Spending Account

The IRS limits how much you can contribute each year into a Dependent Care FSA. The “use it or lose it” rule also applies to Dependent Care FSA. You can be enrolled in both a Dependent Care FSA and HSA.

You may choose the 9 month option with deductions from your January through May and September through December paychecks or you may choose the 12 month option with deductions from your January through December paychecks.

Expenses paid through your Dependent Care spending account must be incurred solely for the purpose of either allowing both you and your spouse to work or look for work; or allowing you to work while allowing your spouse to attend school full-time. Furthermore, these expenses must be for the care of a child under age 13, or for a dependent who is not capable of self-care. If you are paying an individual for day care services, that person will need to report any income received from you to the IRS.

You will need to provide the name, address and social security number/tax identification number of your day care provider on your reimbursement claim form and federal income tax forms.

You will be reimbursed from the Dependent Care spending account only up to the amount you have contributed at any given time. If you submit a reimbursement claim which is larger than your account balance at that time, you will be reimbursed your full account balance and then continue to be reimbursed from your account as new contributions are made.

Examples of eligible dependent care expenses include:

- Costs for a day care center.
- Costs for a caregiver for dependent day care provided inside or outside your home.
- Costs for day care provided to legally dependent adults who are physically or mentally unable to care for themselves. (Legally dependent adults must spend a minimum of eight hours a day in your home.)

Examples of ineligible dependent care expenses include:

- Weekend, evening and summer babysitting not work-related.
- Nursing home expenses.
- Amounts paid to an immediate family member under age 19 or to another dependent.
- Tuition expenses for schooling beginning with the first grade.

Please check with your tax advisor to help you determine whether the current dependent care income tax credit or the Dependent Care FSA will be most beneficial to you based upon your income and tax bracket.
Requesting Reimbursement from Section 125 FSA Spending Accounts

Reimbursements from the District’s Section 125 Flexible Spending Accounts (FSA) will be processed by Surency Life and Health, the District’s FSA provider. You will receive a debit card in the mail from Surency. You will be able to use the debit card to make payments from your FSA account(s). You are not required to use the debit card to pay expenses. You can request reimbursement through your on-line Surency account or print a claim form to email, fax or mail to Surency. Upon enrollment into an FSA, you will receive an enrollment packet which will contain additional information.

A Final Word on Flexible Spending Accounts

The pre-tax savings accounts are designed to save you money and provide more take home pay. While they do not eliminate your out-of-pocket health care and dependent care expenses altogether, they can reduce your expenses significantly -- for most people by 20%, 30% or more.

If you are like most people, 20% or 30% savings can add up to hundreds or even thousands of dollars a year. If that kind of savings is worth a little of your time to plan ahead and calculate your eligible expenses for the coming year, the spending accounts may make sense for you. Do not let the rules and regulations intimidate you. The federal government imposes those rules simply to prevent people from abusing the tax break that spending accounts offer. If you estimate your expenses carefully -- even conservatively -- and submit your claims regularly, you can work within the rules and manage to save yourself a great deal of money in the process.

This plan highlight is a summary provided to help you understand your insurance coverage. Please refer to your Plan Document for a complete plan description. The plan document can be found on the Lee’s Summit School District website at [http://benefits.ls7.org](http://benefits.ls7.org). If a conflict arises, the Plan Document will govern in all cases.

Life Insurance

Life insurance is one way of providing financial protection for your survivors. Your coverage amount will be paid to the beneficiary or beneficiaries of your choice in the event of your death while you are still actively employed at Lee’s Summit School District. The life insurance coverage is insured through The Standard.

Basic Life and Accidental Death & Dismemberment

To help protect your financial security, the District provides you group life insurance coverage equal to your annual salary, with a minimum of $10,000, up to a maximum of $300,000 at no cost to you.

If your death is due to accidental causes (as defined by the plan), your beneficiary will receive an additional amount through the accidental death and dismemberment (AD&D) coverage which is also provided by the District. The AD&D coverage is equal to your life insurance coverage amount. AD&D coverage also provides a portion of the benefit in the event of certain accidental injuries not resulting in death.

Other Basic Life Features and Services

- Right to convert provision, upon resignation, retirement or termination from the District
- Portability of insurance provision, upon resignation, retirement or termination from the District
- Waiver of premium, determined by The Standard upon disability
- Accelerated Benefit (partial payment prior to death)
- MEDEX Travel Assistance
- Standard Secure Access account payment option to beneficiaries

For additional information regarding these services, please contact the District’s Business Services Department at (816) 986-1000 or by email at [benefits@ls7.net](mailto:benefits@ls7.net).

Dependent Life Insurance

You may also elect to purchase dependent life insurance for your spouse and/or your unmarried dependent child (ren), up to the age of 26, on a voluntary basis through payroll deduction. You may also elect this coverage for adult disabled children over the age of 26 however a verification form must be completed. Please contact the District’s Benefits Coordinator to obtain the verification form. The benefit available to your spouse and/or dependents is $10,000 each.

Your spouse and/or dependent child (ren) are not eligible for this coverage if they are a full-time member of the armed forces.

If your spouse is also employed by the District, you cannot enroll him/her for this additional life insurance coverage. Also, only one employee can elect additional life insurance on any dependent child (ren) you may have.

Supplemental Life Insurance

You may also elect to purchase an additional amount of supplemental life insurance on yourself, on a voluntary basis through payroll deduction. You may elect a benefit amount equal to one times your annual salary, to a maximum of $300,000 or an amount equal to two times your annual salary, to a maximum of $400,000. This coverage is guaranteed issue if you enroll when first eligible. If you decline the coverage as a new hire and wish to enroll at a later date, medical underwriting applies and your coverage is subject to approval by The Standard. Therefore, if this is your annual open enrollment period and you currently do not have the District’s supplemental life insurance, or are requesting an increase, you will need to complete an Evidence of Insurability form found on the enrollment site.

Under these policies, insurance coverage reduces by 8% at age 65; by 55% at age 70; and by 70% at age 75. Upon separation of employment, you have the right to convert and/or port your coverage on an individual basis.

The monthly cost for your 2018 coverage will be as follows. The premiums will be deducted from your paycheck one month prior to the coverage effective date.
Life Insurance Beneficiaries

There are two types of life insurance beneficiaries: Primary (First) and Contingent (Secondary).

A Primary (First) beneficiary is the person or persons who would receive your life insurance proceeds in the event of your death. You may designate more than one beneficiary however the total Primary beneficiary designated percentage must total 100%.

A Contingent (Secondary) beneficiary is the person or persons who would receive your life insurance proceeds if every Primary beneficiary is not living at the time of your death. You may also designate more than one beneficiary however the total Contingent beneficiary designated percentage must total 100%.

NOTE: Basic Life beneficiaries and Supplemental Life beneficiaries do not need to be the same. If you wish to designate a minor as your beneficiary you may want to seek legal advice.

If you do not designate a beneficiary, or if none of the beneficiaries you designated are living at the time of your death, payment will be made to your estate.

It is very important you keep your life insurance beneficiary designations current and up-to-date. Beneficiary information can be changed at any time during the year by using Employee Online.

If you are a new enrollee, you will enter your beneficiary information during the on-line enrollment process. Make sure you have their names, addresses and phone numbers available when you complete your new hire enrollment.

If you are currently enrolled, beneficiary information previously provided to the District is on file. You can find your current life insurance beneficiary designations in the Life Insurance Beneficiaries section of Employee Online.

Disability Insurance

One of the most important items to insure is your ability to earn a living. Should a sickness or injury strike, your out-of-pocket expenses -- not to mention lost time on the job -- can impact the financial well-being of you and your family. The Lee's Summit School District's disability plans can help replace a portion of your salary in the event of a covered medical condition or off-the-job accidents. The cost of these coverages is paid by Lee's Summit School District. These plans are insured through The Standard. To receive benefits your claim must be submitted to and approved by The Standard.

Short Term Medical Leave (STML)

The District provides, at no cost, regularly scheduled employees (full- and part-time) receiving compensation included in a District contract and/or compensation summary, with a Short Term Medical Leave (STML) plan administered by The Standard. Regularly scheduled is defined as working in a position required during the hours and days of the student attendance calendar authorized for the school term. STML provides paid leave and continuation of insurance coverage to eligible employees when they are unable to work for an extended period due to a serious non-work related health condition. Pregnancy-related medical conditions which meet the requirements of this plan are covered on the same basis as any other qualifying health condition.

Eligibility Waiting Period

Newly hired employees shall become eligible for STML after having worked 90 regularly scheduled contract and/or compensation summary working days following their hire date. Hire date is defined as the first day of an employee’s contract and/or compensation summary for which compensation is earned. A whole or partial day worked is considered a day worked for purposes of satisfying the eligibility waiting period. Personal leave, vacation time, and/or any other whole day absence will not be considered a day worked for purposes of satisfying the eligibility waiting period. However, professional absences approved by the employee’s supervisor will be considered a day worked for purposes of satisfying the eligibility waiting period.

Benefit Waiting Period

To qualify for STML benefits, and to continue receiving benefits, your claim must be submitted to and approved by The Standard, the District’s STML administrator. You must use existing applicable paid leave (PDO/PTO and/or VAC/VTO) for the first 10 working days (days may be consecutive or non-consecutive) of absences due to the same qualifying medical condition. If your paid leave is insufficient to cover absences, your pay will be docked accordingly. After the waiting period, you are not required to use all your available leave balance(s) before receiving approved STML pay.
Salary and Benefit Continuation Plan

If you are absent from work because you have a qualifying medical condition approved by The Standard, the salary continuation plan will provide you with a benefit equal to 100% of your regular salary beginning on the 11th day of absence due to the same qualifying medical condition. Regular salary consists of pay included in a contract and/or compensation summary. If applicable, your insurance benefits will continue while receiving STML benefits. You will NOT receive STML pay until the District receives The Standard’s approval of your STML claim.

If approval is not received by the end of your waiting period, you will be required to use paid leave (or be docked in pay if no leave available) until approval is received from The Standard. Once approval is received, any leave (or dock in pay) you used that is subsequently paid as STML will be reinstated in your leave bank balance (if dock, paid back to you) on the next available payroll. If your claim is denied, paid leave (dock) will not be reinstated and you will be expected to return to work immediately.

STML benefits may continue for up to a maximum of 115 working days. A whole or partial day of STML will be considered one day of the maximum benefit period. The total number of working days you may be absent for the same medical condition is 125 days, which includes the 10 day benefit waiting period and the 115 STML days. NOTE: Employment from the District will end upon usage of the maximum STML benefit of 115 working days, if no other leave options are available. The District provides Long Term Disability which is designed to provide benefits when STML has ended, if you are approved for Long Term Disability.

Returning to Work

The Standard and/or the District may require you to present a certification of fitness to return to work. Employees who are medically capable of returning to work on a part-time basis or in another position for which they are qualified by training or experience may be required to perform such services as a condition of receiving STML or in lieu of receiving STML.

To ensure an easy transition back to work, you may be contacted by a Return-To-Work Consultant from The Standard prior to returning to work and/or upon your return to work.

End of Short Term Medical Leave

Short Term Medical Leave will end the earliest of the: 1. date determined to be no longer qualified for the leave, 2. date the employee has received up to 115 paid leave days for the condition, 3. date of death, 4. date employment with the District ends, 5. date employee fails to furnish proof of continuation of disability, or 6. date employee refuses to be examined, if District or The Standard requires an examination.

Coordinating Short Term Medical Leave and Family and Medical Leave Act (FMLA).

If you are entitled to the benefits of Family and Medical Leave (FMLA), your FMLA leave and Short Term Medical Leave will run concurrently. Please refer to Board Policy GBBDA for FMLA eligibility requirements and additional FMLA information.

How to Apply for Short Term Medical Leave

To begin the process of applying for STML, please request a “Short Term Medical Leave-Employee Information Form” from the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

Long Term Disability (LTD)

Long Term Disability (LTD) provides coverage for extended disabilities after your STML benefit is exhausted and is administered by The Standard. The Long Term Disability plan highlights include:

- Salary replacement equal to 66 2/3% of the first $15,000 of monthly pre-disability earnings, reduced by deductible income (e.g., work earnings, worker’s compensation, state disability payments, etc.).
- A maximum benefit of $10,000 per month.
- Payment duration of up to Social Security Normal Retirement Age.
- 24-hour coverage, including for work-related disabilities.
- During periods of total disability, waiver of life insurance premium applies.
- LTD payments received are taxable income.

Disability is defined during the benefit waiting period and for the first 36 months for which LTD benefits are paid, as being unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of the employee’s own occupation and suffering a loss of at least 20% of pre-disability earnings when working in the employee’s own occupation.

After that, being unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any gainful occupation which the employee is able to perform, due to education, training or experience; is available at one or more locations in the national economy; and the employee can be expected to earn at least 60% or more of pre-disability earnings within 12 months of returning to work, regardless of whether the employee is working in any other occupation. The employee is not disabled when earning 60% or more of pre-disability earnings in any occupation.

Workers’ Compensation

As required by Missouri law, the District carries Workers’ Compensation insurance. If you are injured on the job, Workers’ Compensation insurance benefits which may be available to you are as follows:

- Medical Care*
- Payments for lost wages
- Compensation for permanent disability
- Survivor benefits

*Missouri law allows the District to choose the health care provider to treat your injury. Treating with your personal physician may jeopardize your ability to receive workers’ compensation benefits.
Workers’ Compensation (con’t)

The Lee's Summit R-7 School District is a member of a self-insurance pool Missouri United School Insurance Council (MUSIC), which provides Workers’ Compensation coverage within the state of Missouri. The claims are administered by Gallagher Bassett Services on behalf of the District. Workers’ Compensation is basically no fault insurance for injuries that are sustained while employees are within the course and scope of employment, subject to applicable Missouri law. Benefits for injuries determined to be compensable include payment for medical treatment, payments for lost wages, and if applicable, payments for permanent handicaps. These benefits are explained in more detail below.

For serious or life threatening injuries, call 911 or transport the injured employee to the nearest emergency room, Lee's Summit Medical Center, or Saint Luke's East Hospital. Contact the District's Workers' Compensation Office as soon as reasonably practical, 816.986.1049, 816.986.1048, or 816.329.9353. After hours: 816.329.9353, Fax: 816.986.1168.

Steps To Follow For Work Related Injuries:

1. Directly report an injury to your immediate supervisor.

2. Complete the "Employee Injury-Incident Report", if physically able to do so. File the report with the District's Workers' Compensation Office, within Business Services, at the Stansberry Leadership Center, 301 NE Tudor Road, Lee's Summit, MO 64086, 816.986.1049, 816.986.1048, or 816.329.9353. After hours: 816.329.9353, Fax: 816.986.1168. By Missouri Law, the District has the right to direct medical care for work related injuries. The District is not responsible for payment of any unauthorized medical treatment or treatment provided by a personal physician. Should you receive any bills for authorized work related injury medical treatment, please forward these to the District's Workers' Compensation Office in Business Services at Stansberry Leadership Center, 301 NE Tudor Road, immediately.

3. Injured workers should first visit the building’s Health Room, if available. If medical treatment beyond first aid is required, contact Charlie Minton (986.1049) or Sara McMillin (986.1048 or 329.9353) to obtain authorization and an appointment time at the Corporate Care’s regular business hours, injured employees should seek treatment at CareNow, located at 228 NW Oldham Parkway, Lee's Summit, MO 64081, P: 816.600.4075 or The Urgency Room, 2741 NE McBaine Drive, Lee's Summit, MO 64064, 816.554.2600. For safety reasons, please have someone transport you to the medical facility.

4. If treatment at the Complete Health & Wellness Center is unavailable or not appropriate for the injury, authorization is needed and will be provided through the “MUSIC Workers’ Compensation Treatment Authorization”. (Note: this form will be used for the treatment at all locations other than the Complete Health & Wellness Center and will be provided by the District to the provider- employees DO NOT need the form to obtain treatment). Employees will be directed to Corporate Care, 805 NE Rice Road, Lee's Summit, MO 64086, Phone: 816.554.1518, during regular business hours (Monday-Friday, 8am to 5pm). After Corporate Care’s regular business hours, injured employees should seek treatment at CareNow, located at 228 NW Oldham Parkway, Lee's Summit, MO 64081, P: 816.600.4075 or The Urgency Room, 2741 NE McBaine Drive, Lee's Summit, MO 64064, 816.554.2600. For safety reasons, please have someone transport you to the medical facility.

5. For the first prescription filled related to an injury, complete the bottom portion of the “First Fill Information Missouri United School Insurance Council” and take it to a pharmacy. This form is available from the Complete Health & Wellness Center, or the District’s Workers’ Compensation Office. This form allows you to receive a prescription at no cost.

6. If additional medical services beyond the initial evaluation are needed, pre-authorization is required. Pre-authorization may be available from the staff at the Complete Health & Wellness Center or from the District’s Workers’ Compensation Office (816.986.1049, 816.986.1048, or 816.329.9353). After hours: 816.329.9353).

7. Your initial evaluation at a medical facility is considered time worked if the visit occurs during regular working hours. However, follow-up appointments, including physical therapy, if applicable, require the use of personal or vacation leave if scheduled during regular working hours.

Payment for Lost Wages

Some injuries may keep you from working temporarily. You may be eligible to receive “temporary total disability” (TTD) payments until the authorized treating physician indicates you are able to return to work. Temporary total disability is paid at 2/3rds of your average weekly wage and is not subject to federal, state or social security taxes. TTD payments do not begin until you are off work the fourth scheduled working day. The first three missed working days require employees to use personal time or take a dock in pay. Injured employees may be accommodated with modified or alternative job duties based on work restrictions. Regular wages are paid during periods of accommodation with modified or alternate work.

The District will continue the contribution to the employee's health and or dental coverage, if applicable during the time the employee is unable to work. If an employee's pay includes deductions for health, dental or vision coverage, the employee is required to pay their portion of the premium to the District by the 20th of each month. Employees will be notified in writing of any amounts that are due to the District for insurance premiums. Employees will also continue to accrue leave during the time they are receiving TTD payments.
Payment for Lost Wages (con’t)

If an employee chooses to apply for retirement service credit for the period of time that he/she is unable to work, the employee will be required to pay their portion of the retirement and the District will match the retirement contribution. The request to apply for retirement service credit must be completed within two (2) years from the end of the school year in which the work related injury absence occurs. For questions regarding retirement service credit, please contact the District’s Benefit and Wellness Coordinator at 816.986.1048.

Additional Benefits

If there is a permanent handicap involved with your injury, the treating physician will advise that you have sustained a permanent partial (referring to a portion of the body) disability relative to your injury and provide the claims administrator with his opinion of the amount of disability sustained. Your claim would then be set by the Division of Workers’ Compensation. A lump sum settlement may be made based upon the information provided by the treating physician.

Additional Questions Or Assistance

District’s Workers’ Compensation Office, within Business Services, at the Stansberry Leadership Center, 301 NE Tudor Road, Lee’s Summit, MO 64086, 816.986.1049, 816.986.1048, 816.329.9353. After hours: 816.329.9353, Fax: 816.986.1168.

Complete Health & Wellness Center is located 600 NW Murray Road, Suite 103, Lee’s Summit, MO 64081. The Center’s business hours are: Monday – Thursday, 7 am to 11:30 am and 12:30 pm to 6 pm, Friday, 7 am to 12 pm, Saturday, 8 am to 11 am, Sunday, Closed. 24/7 Phone: 1.877.423.1330.

Long Term Care Insurance

Unexpected events, such as a serious illness or accident, as well as the aging process, can leave you in a vulnerable position -- both personally and financially. You may know of someone who is caring for a family member, or you may be caring for someone yourself. Who would take care of you if you needed help, and how would you pay for that care? To help ease this burden, Lee’s Summit School District offers a long term care insurance plan through Unum Life Insurance Company of America.

What is long term care? It is the type of care received either at home or in a facility, when someone needs assistance with activities of daily living (bathing, dressing, toileting, transferring, continence and eating), or suffers severe cognitive impairments (such as Alzheimer’s disease).

UNUM’s long term care plan allows you to maintain choice and control over your life by allowing you to choose who will give you care and where you will receive care. It also allows you to maintain control of how your benefits and assets are used.

Not only can you purchase long term care insurance for yourself, you can also purchase it for your spouse, parents, grandparents, siblings and in-laws (the maximum issue age is 80), but the entire amount of their coverage will be subject to medical underwriting and approval by Unum.

Once you qualify for benefits, UNUM pays you a cash benefit each month, according to the level of coverage you have selected. The money can be used for any reason that you choose. There are no invoices to keep track of or bills to submit.

Why buy now? Because the younger you are when you buy UNUM’s long term care insurance, the lower the cost. Also, if you are a new hire, you are guaranteed coverage (within limits) during your initial enrollment period.

If you are a current employee who has had an opportunity to join this plan in the past, but declined to participate, you can enroll at any time. However, any coverage will be subject to medical underwriting and approval by UNUM. As an active employee or qualifying family member, you may be eligible for this valuable insurance coverage.

To learn more about the specific benefits available or to obtain an application, please visit the District’s information site: www.unuminfo.com/reorganizedschooldistrict. This site contains additional information and all necessary enrollment materials for you to enroll in Long Term Care coverage. If you have questions or prefer your enrollment materials to be printed and mailed to your home address, please call UNUM at 1.800.227.4165.

Any amount of long term care insurance that requires medical underwriting will be effective according to the following schedule:

- If coverage is approved between the 1st and the 15th of a month, coverage will be effective first of the month following approval.
- If coverage is approved between the 16th and 31st of a month, coverage will be effective first of the next month following approval.

Accordingly, the additional premium will not be payroll deducted until the first of the month following approval. Also, if your spouse is applying for coverage, his/her long term care insurance will be effective according to the above schedule as well. Payroll deductions for spouse coverage will not begin until the first of the month following approval.

If you resign, retire or are terminated from the District, you will be eligible to continue your coverage at the same monthly rate you are paying as an employee. For additional information on continuation of your Long Term Care insurance, please review the section in this guide titled, “Benefits Continuation After Separation from District.”
Benefits Continuation After Separation from District

When you separate your employment from the District due to retirement, resignation or termination, you are no longer eligible for District-paid insurance coverage. You, your spouse and/or dependent children are eligible to continue insurance coverage for medical, dental and/or vision if currently enrolled. Depending on your separation status, the following options are available for continuing these benefits:

- Retiree Group Coverage
- COBRA

Determining Last Day of Coverage as Active Employee

Upon your retirement, resignation or termination from the District, active employee insurance coverage for medical, dental and/or vision will end. Your last day of coverage as an active employee is determined based upon a number of factors. Please contact the District’s Benefits Coordinator at (816) 986-1048 to confirm your last day of coverage. Applicable insurance premiums will be deducted on your final payroll check from the District.

Continuation of Coverage-Retiree Group Coverage

If you are eligible to receive immediate retiree benefits from PSRS or PEERS, you and your eligible family members may continue participation in the District’s:

1. Medical and/or Dental plans as a Retiree participant
2. Employee Assistance Program (EAP) and/or Vision plans as a COBRA participant.

Approximately three weeks after your last day worked, you will receive two mailings from CBIZ COBRA Retiree Billing, the District’s COBRA/Retiree group coverage administrator.

One mailing will include a “Retiree Benefit Plan Enrollment form.” This form will need to be completed in order to continue your current medical and/or dental coverage. Please read the Retiree continuation of coverage packet carefully and follow the directions included for completion of this form.

Another mailing will include a “COBRA Continuation Coverage Election” form. This form will need to be completed in order to continue your Employee Assistance Program (EAP) and/or vision coverage. These benefits can continue for 18 months. Please read the COBRA continuation of coverage packet carefully and follow the directions included for completion of this form.

If you do NOT enroll in the District’s Retiree Group coverage upon your retirement, you will have two annual open enrollment opportunities following your date of retirement in which to become a member. For example, if you retire in May 2018, you will have the opportunity to enroll for retiree benefits in November 2018 and/or November 2019 (for coverage effective 01/01/20). In this example, if you have not elected retiree insurance coverage by 01/01/20, you are no longer eligible to participate in the District’s Retiree Group coverage.

In addition, after the two open enrollment periods, if you are enrolled in benefits as a retiree, but decide to cancel your District’s Retiree Group coverage, you are then NO longer eligible to participate in the District’s Retiree Group coverage.

Upon the death of a retiree covered under the District’s Retiree Group coverage, the surviving spouse and/or eligible dependent children who are currently on the plan may continue to be members of the District’s Retiree Group coverage.

Missouri Statute 169.590 indicates Retiree Group coverage rates must be the same rate the District pays for all other members of the District’s group insurance plans.

The monthly cost for 2018 Retiree coverage can be found on page 37. Premiums will be paid directly to CBIZ, the District’s Retiree group coverage administrator.

Continuation of Coverage-COBR

If your employment with the District ends for any reason other than retirement from PEERS/PSRS, you and your eligible family members may continue participation in the District’s medical, dental, vision and/or Employee Assistance Program (EAP) per the Federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

Approximately three weeks after your last day worked, you will receive a mailing from CBIZ COBRA Retiree Billing, the District’s COBRA/Retiree group coverage administrator.

The mailing will include a “COBRA Continuation Coverage Election” form. This form will need to be completed in order to continue your current coverage. Please read the COBRA continuation of coverage packet carefully and follow the directions included for completion of this form and adhere to all deadlines.

If you elect COBRA, you do not have to send payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after your election. (This is the date the Election Notice is post-marked, if mailed.) Benefit coverage will not be reinstated until payment is received by CBIZ Payroll. If you do NOT make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the District’s COBRA plan. Additional payment processes will be explained in the continuation letter you receive from CBIZ Payroll.

COBRA generally provides continuation of coverage for only up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, COBRA coverage may be continued for up to a total of 36 months. The monthly cost for 2018 COBRA coverage can be found on page 38. Premiums will be paid directly to CBIZ, the District’s COBRA administrator.
# Retiree Medical Plan Costs

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueSelect Plus (HDHP)</strong></td>
<td></td>
</tr>
<tr>
<td>Retiree Only</td>
<td>$456</td>
</tr>
<tr>
<td>Retiree &amp; Spouse</td>
<td>$936</td>
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<td>Retiree &amp; Child(ren)</td>
<td>$802</td>
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<tr>
<td>Full Family</td>
<td>$1,381</td>
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<tr>
<td><strong>Preferred Care Blue (HDHP)</strong></td>
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<tr>
<td>Retiree Only</td>
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<tr>
<td>Retiree &amp; Spouse</td>
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<td>Full Family</td>
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<tr>
<td><strong>Basic HMO</strong></td>
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<tr>
<td>Retiree Only</td>
<td>$701</td>
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<tr>
<td>Retiree &amp; Spouse</td>
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<td>Retiree &amp; Child(ren)</td>
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<td>Full Family</td>
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<tr>
<td><strong>Buy-Up HMO</strong></td>
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<tr>
<td>Retiree Only</td>
<td>$737</td>
</tr>
<tr>
<td>Retiree &amp; Spouse</td>
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<td>Retiree &amp; Child(ren)</td>
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<tr>
<td><strong>PPO</strong></td>
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<tr>
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<td>Retiree &amp; Child(ren)</td>
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<td>Full Family</td>
<td>$2,443</td>
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# Retiree Dental Plan Costs

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Plan</td>
<td></td>
</tr>
<tr>
<td>Retiree Only</td>
<td>$18.82</td>
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<tr>
<td>Retiree &amp; Spouse</td>
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<td>Retiree &amp; Child(ren)</td>
<td>$51.60</td>
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<tr>
<td>Full Family</td>
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<tr>
<td>Retiree Only</td>
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<tr>
<td>Retiree &amp; Spouse</td>
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<td>Retiree &amp; Child(ren)</td>
<td>$98.72</td>
</tr>
<tr>
<td>Full Family</td>
<td>$131.58</td>
</tr>
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</table>
### 2018 Employee Benefits Program

#### COBRA Medical Plan Costs

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueSelect Plus (HDHP)</strong></td>
<td></td>
</tr>
<tr>
<td>Member Only</td>
<td>$465.12</td>
</tr>
<tr>
<td>Member &amp; Spouse</td>
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<tr>
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<tr>
<td>Full Family</td>
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<tr>
<td><strong>Preferred Care Blue (HDHP)</strong></td>
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</tr>
<tr>
<td>Member Only</td>
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</tr>
<tr>
<td>Member &amp; Spouse</td>
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<td>Member &amp; Child(ren)</td>
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<tr>
<td>Full Family</td>
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<tr>
<td><strong>Basic HMO</strong></td>
<td></td>
</tr>
<tr>
<td>Member Only</td>
<td>$715.02</td>
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<tr>
<td>Member &amp; Spouse</td>
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<tr>
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<tr>
<td>Full Family</td>
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<tr>
<td><strong>Buy-Up HMO</strong></td>
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<tr>
<td>Member &amp; Child(ren)</td>
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<tr>
<td><strong>PPO</strong></td>
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<tr>
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<tr>
<td>Member &amp; Child(ren)</td>
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<tr>
<td>Full Family</td>
<td>$2,491.86</td>
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#### COBRA Dental Plan Costs

<table>
<thead>
<tr>
<th>Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Plan</strong></td>
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<td>Member Only</td>
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<tr>
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<tr>
<td>Member &amp; Child(ren)</td>
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<tr>
<td>Full Family</td>
<td>$71.07</td>
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<tr>
<td><strong>Buy-Up Plan</strong></td>
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</tr>
<tr>
<td>Member Only</td>
<td>$36.25</td>
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<tr>
<td>Member &amp; Spouse</td>
<td>$71.81</td>
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<td>Member &amp; Child(ren)</td>
<td>$100.69</td>
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<tr>
<td>Full Family</td>
<td>$134.21</td>
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</table>

#### COBRA Vision Plan Costs

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</thead>
<tbody>
<tr>
<td><strong>Basic Plan</strong></td>
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<tr>
<td>Member Only</td>
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<td>Member &amp; Spouse</td>
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<td>Full Family</td>
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#### COBRA Employee Assistance Program

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>$1.31</td>
</tr>
<tr>
<td>Full Family</td>
<td></td>
</tr>
</tbody>
</table>
Continuation of Other Benefits Upon Leaving the District

Many employees have other types of benefits in addition to medical, dental, vision and EAP. Some of the most common types of other benefits are referenced below.

**Disability Insurance**

Short Term Medical Leave and Long Term Disability insurance coverage ends the last day worked.

**Health Reimbursement Arrangement (HRA)**

If you have a balance in your HRA account, you may continue to file claims for reimbursement through the end of the plan year in which your employment ends for services provided during the plan year. For example, if your last day worked is May 18, 2018, you may file claims for reimbursement for covered expenses incurred through December 31, 2018. Any unused funds are forfeited.

**Health Savings Account (HSA)**

If you are no longer enrolled, either through Retiree Group, COBRA coverage, or individual coverage in a Qualiﬁed High Deductible Health Plan, you are no longer eligible to make contributions to your Health Savings Account (HSA). You will be able to continue to access accumulated funds in your HSA to pay for eligible expenses until your HSA is depleted. Please contact Central Bank of the Midwest at (816) 525-5300 for additional information and other available options.

**Life Insurance**

Life insurance coverage ends the last day worked. However, you may be eligible to buy portable or convertible group life insurance coverage. Please contact the District’s Beneﬁts Coordinator at (816) 986-1048 for additional information regarding continuation of your life insurance coverage.

**Long Term Care Insurance**

Long Term Care insurance ends the last day worked. However, you are eligible to continue your coverage at the same monthly rate you were paying as an active employee. The District’s Beneﬁts Coordinator will provide to you a Continuation Request Form from UNUM, the District’s Long Term Care insurance provider. You will have 31 days after your coverage end date to request continuation of your Long Term Care insurance to UNUM.

**Section 125 Flexible Spending Accounts (FSA)**

Section 125 Flexible Spending Accounts (FSA) include: Medical, Limited and Dependent Care. If you have a balance in your FSA Account(s), you may continue to file claims for reimbursement from those accounts, but only for covered expenses incurred through the last day of the month in which your employment ends. Any unused funds are forfeited. All claims for payment of those expenses must be submitted within 90 days after the end of the month in which your employment ends. For example, if your last day worked is May 18, 2018, you may file claims for reimbursement for covered expenses incurred through May 31, 2018 and you must submit your reimbursement request by August 29, 2018.
Payment for Unused Leave Upon Leaving the District

Unused Paid Days/Time Off (PDO/PTO)

Employees who are eligible to receive immediate retiree benefits from the Public School Retirement System of Missouri (PSRS) or the Public Education Employee Retirement System (PEERS) shall be paid for all unused Paid Days/Time Off at 90 percent of their daily/hourly rate, excluding extra duty pay. Staff must also meet the following minimum eligibility requirements (per Board Policies GCBDA and GDBDA):

1. Must have ten years of experience in the District and be 55 years old; OR
2. Must have ten years of experience in the District and 25 years of service in either PSRS or PEERS.

If you do not meet the above requirements, please refer to Board Policy GCBDA-AP3 or GDBDA-AP3, for payment information.

All unused PDO/PTOs will be paid to you on your final payroll check from the District. Employees working less than a full term will only be entitled to a prorated share of PDO/PTO hours based upon length of employment during the current school year compared to a full term of employment.

Unused Vacation Days/Time Off (VAC/VTO)

Twelve month employees who retire, resign or are terminated from the District, shall be paid for all unused Vacation Days/Time Off at 100 percent of their daily/hourly rate, excluding extra duty pay.

All unused VAC/VTOs will be paid to you on your final payroll check from the District. Employees working less than a full term will only be entitled to a prorated share of VAC/VTO hours based upon length of employment during the current school year compared to a full term of employment.

Employee Online

Employee Online (EO) is a web-based system designed to provide employees with access to important personal, payroll and benefit information. EO allows the viewing or modification of items such as addresses, emergency contact information, pay check stubs, direct deposit, tax status, miscellaneous payroll deductions, current benefit plans and position information. Your pay stub will be available through EO. EO also contains an employee directory to assist you with communicating with other staff members for business purposes.

New Employees

You will receive a letter from the Business Services Department requesting you review and enter the following information in EO within two weeks of your hire date. (NOTE: The first time you log into EO, your password is your social security number. You will be prompted to change your password at that time.)

1. Review your Personal Information and update if changes are necessary,
2. Enter your Emergency Contact Information,
3. Enter your Direct Deposit Information (NOTE: It is mandatory for all staff to be on direct deposit. You will receive a check until your direct deposit has been setup), AND
4. If you are a resident of Kansas City, MO, select to withhold the Kansas City Earnings Tax of 1% under the miscellaneous payroll deductions link.

Accessing Employee Online

You can access EO from inside or outside of the District. EO may be accessed in one of two ways:

1. Open the internet and type eo.lsr7.org in the address bar OR
2. Go to the District website (http://www.lsr7.org), select “Staff” and then select “Employee Online” under the Employee Apps section.

Message Page - Payroll Deadline Dates

Once logged onto EO, a “Message Page” will be displayed. Please be sure to read the Message Page as it will provide timely information and announcements. Most importantly, the dates on this screen indicate the deadline date for making changes in EO on your next pay check.

Employee Online Video Tutorials and Assistance

To assist you in using EO, video tutorials have been developed that will take you through each component of EO. The tutorials can be found by going to the District website (http://www.lsr7.org), select “Staff,” then select “Employee Online” under Employee Apps.

For staff members who do not have internet access at work or home, computers are available for use in the Business Services Department located at Stansberry Leadership Center. If you need further assistance or have questions, please email EOHelp@lsr7.net.
Public School & Education Employee Retirement Systems of Missouri

The Public School and Education Employee Retirement Systems of Missouri (PSRS/PEERS) provide a significant and stable source of retirement, disability and survivor benefits to Missouri's public school teachers, school employees and their families. PSRS and PEERS are Defined Benefit (DB) pension plans providing lifetime retirement benefits to qualified members based on a formula set by Missouri law.

PSRS/PEERS work in partnership with the member school districts of Missouri to provide eligible employees and their beneficiaries with a significant source of income based on the employee's length of service and salary in order to enhance retirement, disability and death benefits received from other sources.

Funding

PSRS/PEERS' funding comes from three sources: member contributions, employer contributions and investment earnings. Investment earnings are the primary source of funding for PSRS/PEERS benefits. On average, 63 cents of every dollar paid to PSRS/PEERS retirees comes from investment earnings.

Contribution Rate

The employee and employer contribution rate is set each school year by the PSRS/PEERS’ Board of Trustees. It is based on the recommendation of the Systems’ actuary after the annual actuarial valuation has been completed.

PSRS/PEERS contributions are automatically deducted from your pay, if eligible to participate, and are tax-deferred (not taxed until paid to you as a monthly benefits or as a lump-sum payment). In most cases, the retirement benefits paid to PSRS/PEERS members greatly exceed the funds they contribute to the System while working. In fact, most PSRS/PEERS retirees recover all their contributions within the first five years of retirement.

Your contribution funds are credited to your individual account, and you earn interest on your funds, every June 30.

Membership

- PEERS membership is required, regardless of position, for non-certificated employees employed to work at least 20 hours per week on a regular basis by an employer within the Retirement System in a position that normally requires the employee to work at least 600 hours during the school term.
- PSRS membership is required, regardless of position, for certificated employees employed to work by an employer within the Retirement System in a position that normally requires the employee to work the full school day, or at least the same number of hours per week as required for such a position, and also normally requires the employee to work at least 600 hours during the school term. Certificated employees/teachers employed less than full-time for at least 17 hours per week on a regular basis in a position that requires the employee to work at least 600 hours during the school term may elect membership in PEERS within the first 90 days of their initial part-time employment.

Vesting Period

As a PSRS/PEERS member, once you have earned five years of credit with PSRS/PEERS, you are vested and can receive lifetime retirement benefits when you reach age and service requirements. Vesting may also help you qualify for disability benefits and survivor benefits for your beneficiaries.

Missouri law requires the Systems to maintain a funding level that covers current and anticipated future benefit promises. This guarantees availability of funds to pay benefits as prescribed by law.

Over the years, legislative changes have resulted in improved service retirement benefits, disability benefits and benefits for the beneficiaries of deceased members.

With $37.9 billion (market value) in invested assets and serving more than 248,000 members, PSRS/PEERS is one of the largest retirement systems in the nation.

Since established, PSRS/PEERS has helped more than 100,000 Missouri public school employees and their families achieve financial security and peace of mind during retirement.
Important Advantages

- Disability benefits are available if you have five years of eligible employment and cannot work due to a disability that appears to be total and permanent.
- Survivor benefits may be payable upon your death.
- If you take leave from employment for military service, you may be able to get credit with PSRS/PEERS (to count toward your retirement) for the leave time.
- Purchasing credit with PSRS/PEERS may allow you to reach vested status, retirement eligibility or qualify for a larger benefit.
- Reinstating credit allows you to buy back credit for a membership you previously forfeited by taking a refund of your account balance.
- Your contributions and interest are always returned to you or a beneficiary.

The Importance of a Defined Benefit Plan

As a PSRS/PEERS member, you are a member of a defined benefit retirement plan. Defined Benefit (DB) plans provide members like you predictable income for life, no matter how long you live. The term “defined benefit” is derived from the fact your lifetime retirement benefits are determined by a pre-determined formula that includes:

- A benefit factor set by the Missouri Legislature,
- Your compensation (salary plus District-paid health and dental insurance premiums), and
- Your years of service credit earned while employed by PSRS/PEERS-covered employers and credit purchased.

Unlike defined contribution retirement plans such as IRAs, 403(b) or 401(k) plans, you don’t have to make investment decisions regarding your retirement funds. As a defined benefit plan, PSRS/PEERS can more effectively reduce investment risk, and investment decisions are handled by PSRS/PEERS’ professional investment staff and managers.

And, because PSRS/PEERS is a defined benefit plan, your retirement benefits are payable for your lifetime. The amount of money in your PSRS/PEERS account when you retire does not have a bearing on the amount of benefits you can receive. While defined contribution retirement plans are an important piece of your overall retirement savings, they provide benefits based on account balances in those plans at retirement. That means a retirement based on defined contribution plan savings alone can run out and leave you without the retirement income you need.

When You Can Retire

You are eligible for normal retirement:

- At age 60 with at least five years of credit,
- At any age with at least 30 years of credit, or
- At Rule of 80: when the sum of your age, plus your years of credit, equals 80 or more.

Early retirement options are available, but benefit amounts under these options are reduced. To learn of your early retirement options, please visit the Retirement System’s website at www.psrs-peers.org or contact a Retirement System representative at (800) 392-6848.

Social Security and Medicare - PEERS

- You will pay into Social Security while employed by a PEERS-covered district as long as you do not hold a Missouri Teacher’s Certificate and serving in a position which does not require a Missouri Teacher’s Certificate.
- You should contact Social Security at (800) 772-1213 with your questions or visit their Web site, www.socialsecurity.gov.
- You will also pay into Medicare and are eligible for Medicare Benefits as long as you earn the required number of units and attain the appropriate age.

Social Security - PSRS

- You will not pay into Social Security while employed by a PSRS-covered district as long as you hold a Missouri Teacher’s Certificate and are serving in a position which requires Missouri Teacher Certification.
- You will pay into Social Security while employed by a PSRS-covered district as long as you hold a Missouri Teacher’s Certificate and are serving in a position which does not require Missouri Teacher Certification.
- You should contact Social Security at (800) 772-1213 with your questions or visit their website: www.socialsecurity.gov.
- You will pay into Medicare and are eligible for Medicare Benefits as long as you earn the required number of units and attain the appropriate age.

Pre-Retirement Beneficiary Information

For questions regarding your beneficiary information, please contact a Retirement System representative at (800) 392-6848 as the District does not have access to your beneficiary information.

To change your beneficiary information, please visit the Retirement System’s website at www.psrs-peers.org to complete the required form.

Account Balance/Withdrawal Information

For questions regarding your retirement account balance and/ or withdrawal information, please contact a Retirement System representative at (800) 392-6848 as the District does not have access to your account information.
Tax-Deferred Investments

The Lee's Summit School District offers all employees the opportunity to participate in a 403(b), and/or a 457 tax-deferred investment account through a pretax payroll deduction. This payroll deduction may be established and/or changed at any time. (Note: Roth 403(b) and 457 investments are also available however deductions are taken after-tax.) The District’s 403(b)/457/Roth plan is provided through Cooperating School District Retirement Trust (CSD-RT) utilizing a platform of investment options for 403(b)/475/Roth salary deferrals.

Contribution Limits

The IRS Code has limits on the total contributions you may make in a calendar year. The basic annual contribution limit is established annually by the IRS. The IRS Code also has special catch-up elections. By taking advantage of a catch-up election, you will be able to contribute more than the annual basic limit. For additional information on the special catch-up elections, please visit the Internal Revenue Service website at: http://www.irs.gov/ or consult your financial advisor.

Adding a New Contribution or Changing an Existing Contribution

Instructions for adding a new contribution, changing or ending an existing contribution can be found on the Lee’s Summit School District website at: http://benefits.lsr7.org/benefits-program/tax-deferred-options or in the Business Services Department at Stansberry Leadership Center.

Disclosure

The Lee’s Summit R-VII School District has no liability for the employees’ selection of product providers. The Lee’s Summit R-VII School District does not warrant any special tax consequences to the employee. The Lee’s Summit R-VII School District does not give tax, legal or investment advice. The District recommends employees seek the advice from professionals who specialize in these areas.

Voluntary Deductions

The Lee’s Summit School District allows various voluntary payroll deductions. Voluntary payroll deductions are withheld from an employee’s pay check only if the employee has agreed to the deduction. These payroll deductions maybe established and/or changed at any time. Payroll deduction allows you to designate a fixed portion of your pay check to be sent to any of the following:

Credit Unions

As a District employee, you are a member of the below mentioned credit unions. You will need to contact your credit union of choice to first establish an account.

1. Central Missouri Community Credit Union
   Customer Service:
   Warrensburg (660) 747-3311
   Sedalia (660) 826-6922
   Richmond (816) 776-5593
   Website: http://cmccreditunion.org

2. Community America Credit Union
   Customer Service: (800) 892-7957
   Website: https://www.communityamerica.com

3. Raytown-Lee’s Summit Community Credit Union
   Customer Service: (816) 356-0791
   Website: http://rlsccu.org

After your account has been established, you may request a new payroll deduction or change an existing credit union payroll deduction through the Miscellaneous Payroll Deductions section of Employee Online.

Dues

You may elect to have the following dues deducted from your paycheck:

1. Missouri State Teachers Association (MSTA)
   Telephone: (800) 392-0532
   Website: http://www.msta.org/

2. National Education Association (NEA)
   Telephone: (202) 833-4000
   Website: http://www.nea.org/

To add or change an existing dues payroll deduction, please contact DuesMSTA@lsr7.net for MSTA and DuesNEA@lsr7.net for NEA.

An existing dues payroll deduction can be closed through the Miscellaneous Payroll Deductions section of Employee Online.

Kansas City Earnings Tax

The City of Kansas City, Missouri, has established a one percent (1%) earnings tax on all residents who live or work within the City. In order to facilitate the payment of Kansas City earnings tax, employees may elect to have the District withhold the earnings tax. The earnings tax of one percent (1%) will be deducted from each payroll check and submitted to Kansas City on your behalf. You may elect to start or stop your Kansas City Earnings Tax payroll deduction through the Miscellaneous Payroll Deductions section of Employee Online.

Lee’s Summit Educational Foundation, Inc.

The Lee’s Summit Educational Foundation is a nonprofit organization dedicated to raising private funds to help support programs within the Lee’s Summit School District. The Foundation’s mission is to generate and guide philanthropic resources to promote excellence in education in the Lee’s Summit R-7 Schools. Established in 1993, the Foundation does this by generating and guiding philanthropic resources through personal and corporate contributions, planned giving, and events. For additional information, please contact LSEF@lsr7.net, visit their website at: http://www.lsedfoundation.com/ or call (816) 986-1015.

Employee contributions help fund classroom technology and classroom PEAK Grants which teachers may apply for annually (see https://www.lsedfoundation.com/peak-grants-2/).

You may request a new payroll deduction or change an existing Foundation payroll deduction through the Miscellaneous Payroll Deductions section of Employee Online.
MOST-529 College Savings Plan

MOST 529 is a qualified 529 college savings plan created to comply with Section 529 of the United States Internal Revenue Code which allows you to accumulate tax-deferred (federal and state) savings for secondary education, including graduate school, using low-cost investments. You can use your assets to pay qualified higher-education expenses at any accredited college or technical school in the U.S. or abroad. Enrollment is free and you can begin contributing with as little as $25.

Establishing a New MOST Account:

2. Select “Open an account”
3. Follow the onscreen instructions for “New Account Owners”.
4. After MOST processes your request for a new account, you will receive an electronic confirmation statement.
5. You must sign and submit the confirmation statement to the Business Services Department at Stansberry Leadership Center. Your payroll deduction instructions will not take effect until the Business Services Department has accepted your signed confirmation.

Changing a Current MOST Deduction:

2. Log into your account.
3. Complete the Employee Payroll Direct Deposit Form on-line.
4. After MOST processes your Employee Payroll Direct Deposit Form, you will receive an electronic confirmation statement.
5. You will then need to enter your updated deduction request in the Miscellaneous Payroll Deductions section of Employee Online.

For questions, call MOST toll-free at (888) 414-6678 on business days from 7 am to 8 pm, Central time or visit their website at: https://missourimost.org.

United Way

The District allows after-tax payroll deductions to the United Way of Greater Kansas City. United Way of Greater Kansas City advances the common good by focusing on four key impact areas. Their goal is to create lasting change while working to prevent problems from happening in the first place. For more information regarding United Way’s impact in the Greater Kansas City area, please visit their website at: http://unitedwaygkc.org or contact UnitedWayInfo@lsr7.net. You may request a new payroll deduction or change an existing United Way payroll deduction through the Miscellaneous Payroll Deductions section of Employee Online.

Leaves and Absences

The following leaves with pay will be provided to all full-time regular employees. Part-time regular employees will receive these leaves on a pro rata basis. Please refer to Board Policies GCBD and GDBD for the complete District Policies regarding leaves and absences.

1. Bereavement Leave

Employees shall be granted paid leave not to exceed 5 working days, in the event of a death in the immediate family (excluding miscarriages). The District may require verification of the need for the leave. The Board defines “immediate family” to include:

- The employee’s spouse.
- The following relatives of the employee or the employee’s spouse: parents, stepparents, children, stepchildren, siblings, step siblings, employee’s grandparents, grandchildren or other family members who reside in the same household as the employee.
- Any other person over whom the employee has legal guardianship or for whom the employee has power of attorney and is the primary caregiver.

Employees shall be granted paid leave not to exceed 2 working days, in the event of a death in the extended family (excluding miscarriages).

Extended family shall include grandparents of the employee’s spouse, son-in-law, daughter-in-law, brother-in-law and sister-in-law.

2. Civil Air Patrol Leave

Any employee who is a member of Civil Air Patrol and has qualified for a Civil Air Patrol emergency service specialty or who is certified to fly counternarcotic missions shall be granted unpaid leave to perform Civil Air Patrol emergency service duty or counternarcotic missions without loss of time, regular leave or any other rights or benefits in accordance with law. The leave is limited to 15 working days in any calendar year, but is unlimited when responding to a state- or nationally declared emergency in Missouri. The District may request that the employee be exempted from responding to a specific mission.

3. Coast Guard Auxiliary Leave

Employees who are members of the United States Coast Guard Auxiliary will be granted an unpaid leave of absence for periods during which they are engaged in the performance of United States Coast Guard or United States Coast Guard Auxiliary duties, including travel related to such duties, when authorized by the director of auxiliary or other appropriate United States Coast Guard Authority. Such leaves of absence will be given without loss of time, regular leave or any other rights or benefits to which such employees would otherwise be entitled. The leave is limited to 15 working days in any calendar year, but is unlimited when responding to a state- or nationally declared emergency in Missouri or upon any navigable waterway within or adjacent to the state of Missouri. The District may request that an employee be exempted from responding to a specific mission.

4. Court Subpoena Leave

If the subpoena is directly related to the employee’s school duties, the employee will be released for court appearance without loss of leave. Other court appearances will be deducted from PDO/PTO leave.
5. Crime Victim Leave

Any employee who is a crime victim, who witnesses a crime or who has an immediate family member who is a crime victim will not be required to use vacation or PDO/PTO in order to honor a subpoena to testify in a criminal proceeding, attend a criminal proceeding or participate in the preparation of the criminal proceeding.

6. Election Leave

Any employee who is appointed as an election judge pursuant to state law may be absent on any election day for the period of time required by the election authority. The employee must notify the District at least seven days prior to any election in which the employee will serve as an election judge. No employee will be terminated, disciplined, threatened or otherwise subjected to adverse action based on the employee’s service as an election judge.

7. Firefighter Leave

Employees will be allowed to use PDO/PTO, vacation and/or unpaid leave for any time taken to respond to an emergency in the course of performing duties as a volunteer firefighter.

For the purposes of this section, “volunteer firefighter” includes members of Missouri-1 Disaster Medical Assistance Team, Missouri Task Force One, Urban Search and Rescue Team or those activated by FEMA in times of national disaster. Employees covered under this section shall not be terminated from employment for joining a volunteer fire department or for being absent from or late to work in order to respond to an emergency. Employees shall make every reasonable effort to notify the principal or supervisor if the employee may be absent from or late to work under this section. Employees are required to provide their supervisors with a written statement from the supervisor or acting supervisor of the volunteer fire department stating that the employee responded to an emergency along with the time and date of the emergency.

8. Jury Duty Leave

Employees reporting for jury duty are excused from work for their regularly scheduled shift on the day(s) require for jury duty. The employee will be paid regular pay after submitting receipts showing proof of service, days served, parking, meals and mileage. Forms available for submitting receipts are located in GCBDA-AF1.

Procedures are outlined in GCBDA-AP4. Any amount earned in excess of the receipts must be assigned to the school district. An employee will not be terminated, disciplined, threatened or otherwise subjected to adverse action because of the employee’s receipt of or response to a jury summons.

9. Military Leave

The District shall grant military leaves required by law. Members of the National Guard or any reserve component of the U.S. Armed Forces who are engaged in the performance of duty or training will be entitled to a leave of absence of 120 hours in any federal fiscal year (October 1 – September 30) without impairment of efficiency rating or loss of time, pay, regular leave or any other rights or benefits. Employees shall provide the District an official order verifying that they are required to report to duty.

10. Paid Days/Time Off

Paid time off provides employees greater flexibility in the use of time off.

Exempt Staff-Paid Days Off (PDO)

Federal law defines positions as either Exempt or Non-exempt. Positions which are Exempt are not subject to required additional pay for extra hours worked. If you are paid on a monthly basis, your position is Exempt.

Exempt employees will have his/her full entitlement of PDOS available beginning on his/her first working day of his/her contract. PDO entitlements are granted according to the number of contract working days, as outlined below:

<table>
<thead>
<tr>
<th>Number of Contract Days</th>
<th>PDO Hours Earned in School Year**</th>
<th>Maximum Carryover PDO Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 205</td>
<td>Number of hours worked per day multiplied by 8</td>
<td>Number of hours worked per day multiplied by 21</td>
</tr>
<tr>
<td>205 to 243</td>
<td>Number of hours worked per day multiplied by 9</td>
<td>Number of hours worked per day multiplied by 21</td>
</tr>
<tr>
<td>244 and greater</td>
<td>Number of hours worked per day multiplied by 10</td>
<td>Number of hours worked per day multiplied by 22</td>
</tr>
</tbody>
</table>

*Employees working less than a full term (new hires or separations) will only be entitled to a prorated share of PDO hours based on length of employment during the current school year compared to a full term of employment.

Non-Exempt Staff-Paid Time Off (PTO)

Federal law defines positions as either Exempt or Non-Exempt. Positions which are Non-Exempt are subject to required additional pay at straight time, overtime or comp time for approved additional hours worked. If you are paid on a semi-monthly basis, your position is Non-Exempt.

Non-Exempt employees must earn PTO before it may be used. PTOs will be earned each pay period. At the end of the school year, the total PTO earned will be according to the number of working days, as outlined below:

<table>
<thead>
<tr>
<th>Number of Contract Days</th>
<th>PTO Hours Earned in School Year**</th>
<th>Maximum Carryover PTO Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 205</td>
<td>Number of hours worked per day multiplied by 8</td>
<td>Number of hours worked per day multiplied by 21</td>
</tr>
<tr>
<td>205 to 243</td>
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<td>Number of hours worked per day multiplied by 22</td>
</tr>
</tbody>
</table>

**Employees working less than a full term (new hires or separations) will only be entitled to a prorated share of PTO hours based on length of employment during the current school year compared to a full term of employment.
11. Professional Leave

Employees may be granted professional leave to attend classes or conferences, meet with mentors or participate in other approved professional growth activities. Professional leave must be approved by the employee's supervisor, arranged well in advance and is not considered personal leave.

12. Vacation Days/Time Off

The District grants vacation days in addition to PDO/PTO to all regular employees scheduled to work 244 or more days a school year. Vacation time for management personnel shall be based on the recommendation of the Superintendent and approved by the Board of Education.

Exempt Staff-Vacation Days Off (VAC)

Exempt employees will have his/her full entitlement of VACs available beginning on his/her first working day of his/her contract. VAC entitlements are granted according to the employee's years of service, as outlined below:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Vacation Hours Earned in School Year***</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 years</td>
<td>Number of hours worked per day multiplied by 10</td>
</tr>
<tr>
<td>Greater than 5 years</td>
<td>Number of hours worked per day multiplied by 15</td>
</tr>
<tr>
<td>Greater than 15 years</td>
<td>Number of hours worked per day multiplied by 20</td>
</tr>
</tbody>
</table>

***Employees working less than a full term (new hires or separations) will only be entitled to a prorated share of VAC hours based on length of employment during the current school year compared to a full term of employment.

Non-Exempt Staff-Vacation Time Off (VTO)

Non-Exempt employees must earn VTO before it may be used. VTOs will be earned each pay period. At the end of the school year, the total VTO earned will be according to the employee's years of service, as outlined below:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Vacation Hours Earned in School Year****</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Greater than 15 years</td>
<td>Number of hours worked per day multiplied by 20</td>
</tr>
</tbody>
</table>

****Employees working less than a full term (new hires or separations) will only be entitled to a prorated share of VTO hours based on length of employment during the current school year compared to a full term of employment.

Employees may accumulate up to one and a half times their accrual rate (i.e., an employee with 4 years of service may accumulate up to the equivalent of 15 days). Hours accumulated beyond this maximum shall be automatically forfeited. The only exception is if an employee is not allowed to take his or her vacation because of district needs, in which case the employee shall receive an extension of six months in which to take his or her vacation.

13. Vote

Employees who do not have three successive hours free from work while the polls are open will be granted a leave period of up to three hours to permit the employees three successive hours while the polls are open for the purpose of voting. Requests for such leave must be made prior to Election Day, and the employee's supervisor will designate when during the workday the leave should be taken. Any employee who properly requests leave to vote and uses the leave for that purpose will not be subject to discipline, termination or loss of wages or salary.

Catastrophic Paid Days Off Bank

The Lee’s Summit School District has established a Catastrophic Paid Days Off (PDO) Bank. This bank is designed to ensure that those most in need during a period of catastrophic illness of their own or of their immediate family would have paid leave available. It is not the intent to ensure protection from all situations, but instead to assist in catastrophic situations. Regardless of an employee's application to the Catastrophic PDO Bank, an employee may be eligible for FMLA or STML.

The bank is administered by the District's Human Resources Department. The bank’s resources come from initial and continuing contributions of PDO/PTO's made by all members to the bank. Human Resources then disperses, based upon proper submission and proper medical evidence, days of PDO/PTO's to bank members. Members who receive days do not have to repay the bank. The bank operates much like a long-term disability insurance plan, whereby the insured pays annual premiums for a benefit which, hopefully, need never be collected.

Human Resources does everything in its power to give full and fair consideration to each request, however, the burden of complying with the bank's rules and providing sufficient medical evidence of disability lies entirely with the member. Again, remember that individual employees may be eligible for FMLA or STML while not qualifying for Catastrophic PDO pay.

Joining the Bank

In order to become a member of the bank, an employee must contribute one of their personal days off (PTO/PDO) to the bank.

The contribution will be made electronically on the insurance enrollment website. New employees may contribute to the bank within the first 30 calendar days after employment. If you have not previously donated to the bank, you may contribute to the bank during the District's annual insurance open enrollment. Note: if you have donated to the pool and ended employment with the District, you will have to donate again to become a member after being rehired by the District.
Purpose of the Bank

The purpose of the bank is to provide PTO/PDO’s to members after their accumulated PTO/PDO’s have been exhausted and/or no more than 5 vacation days, if applicable, remain in an employee’s account. Bank use is for illness of a catastrophic nature of the employee, the employee’s spouse, child, parent and/or step-parent.

Definition of Catastrophic

A catastrophic illness is an illness or injury due to a physical or mental impairment (other than those described below*) or which:

1. is of a terminal or life-threatening nature; or,
2. is expected to be of long and indefinite duration and requires:
   a. extended at-home custodial care for an individual who is unable to perform basic living functions without assistance, such as bathing, eating, or dressing; or
   b. in-patient treatment at a licensed hospital or rehabilitation facility.

*The terms “illness” and “injury” shall exclude an illness or injury resulting from alcohol or narcotics abuse, self-inflicted injuries, or engaging in a criminal felony

Requesting Bank Leave

In order to request leave from the bank, an employee had to join the bank and exhaust all advanced and accrued PDO/PTOs. Year round employees will be required to use all but five vacation days prior to applying to the catastrophic bank. To request leave from the bank, follow these steps:

Step 1: Complete the Catastrophic Paid Days Off Claim Form found in Board Policy. For exempt staff, GCBDA-AF4 and for non-exempt staff, GDBDA-AF3.

Step 2: Return the completed form and all required documentation to the District’s Human Resources Department located at Stansberry Leadership Center.

Step 3: The District’s Human Resources Department will then be in contact with you.

Waiting Period

Newly hired employees shall become eligible for coverage under the Catastrophic Bank after having worked 90 working days following their hire date. Hire date is defined as the first day of an employee’s contract and/or compensation summary.

Employees who do not contribute during their new hire enrollment period are eligible to contribute during the next open enrollment period. Employees who contribute during the open enrollment period shall become eligible for coverage after serving a 12-month waiting period. For example, if an employee contributes during the November 2017 open enrollment period, he would be eligible for coverage beginning December 1, 2018.

Limitation on Use of Bank Leave

Members may be eligible for up to 90 days of bank leave for self, spouse, or children who reside in the same household as the employee, with children being defined as those for whom you maintain guardianship or financial responsibilities as verified by federal income tax deduction.

Bank leave shall not be granted in units more than 30 days at a time.

Members may be eligible for up to 30 days of bank leave for member’s parents, step-parents or grown children. Bank leave shall not be granted in units more than 10 days at a time.

Additional Information

Please refer to Board Policies GCBDA-AP2 and GDBDA-AP2 for the entire rules of procedures for the bank. You may also contact the District’s Human Resources Manager at (816) 986-1003 for additional information.

Staff Development Opportunities

The Lee’s Summit School District recognizes professional development and staff learning as an essential component to the process of student learning. All R-7 staff members are encouraged to continue their professional growth and are supported in those efforts. On-site opportunities are made available to both certified and classified staff members. These range from workshops on a variety of topics to graduate-level courses. The District places a high value on its staff and believes that an investment in the employees results in a high return on student learning. The District provides for professional growth by:

- Planned staff development programs and workshops offered within the school district
- Release time for attendance to conferences, workshops and educational meetings
- Advancement on the salary schedule for additional education or training in accordance with Board Policy

For additional staff development opportunities or questions, please contact the District’s Staff Development Office at 816.986.1059 #R7PD

Educational Assistance Program

All regular employees who have been employed for at least one school year are eligible to participate in the District’s educational assistance program, which provides reimbursement of college tuition.

Coursework/Educational Institution Requirements

Coursework taken must be related to the employee’s present job or one to which the employee may be eligible for within the District. Employees must continue working during the time which the coursework is being taken.

Eligible employees must complete courses in a degree/certification program through a college or university on the District approved list which is available at [http://hr.lsr7.org](http://hr.lsr7.org) or by calling (816) 986-1007. Continuing education units will not be eligible for reimbursement or for advancement on the salary schedule (exception for courses offered through Lee's Summit R-7 School District).

A grade of at least a “B” must be earned where grades are given for graduate courses. For courses in which grades are not awarded, (e.g., pass/fail), the employee must present evidence of satisfactory academic standing at the end of each semester to receive reimbursement.
Reimbursement Amounts

Full-time regular employees are eligible to be reimbursed for up to $40 per credit hour up to a maximum of 12 hours per school year.

All part-time regular employees are eligible to be reimbursed for up to $20 per credit hour up to a maximum of 12 hours per school year.

Requesting Tuition Reimbursement

Upon successful completion of all approved course work, follow these steps for requesting reimbursement:

**Step 1:** Log on to [https://www1.lsr7.org/tuitionreimbursement](https://www1.lsr7.org/tuitionreimbursement) (link located on the LSR7 Staff webpage under the Human Resources Tab. Username and Password are the same as your network log in).

**Step 2:** Click ADD CLASS from the menu on the left side of the screen. Complete all fields for each class.

**Step 3:** Click UPLOAD DOCUMENTS to add the Transcript and Proof of Payment.

**NOTE:** Reimbursement requests must be submitted within 12 months of completing the class to be eligible. Any employee who resigns their contract or fails to sign a contract for the following school year will not be eligible to receive reimbursement after their final day of work.

Educational Assistance Additional Information

Please refer to Board Policies GCL-AP2 and GDL-AP for the complete District policies regarding educational assistance. You may also contact the District’s Human Resources Specialist at (816) 986-1007 for additional information.

Staff Discounts and Offers

Because of the rich heritage the Lee’s Summit R-7 School District has with our local business community and because of our mutual commitment to and appreciation of R-7 employees, many discounts, offers and various opportunities are extended to R-7 employees.

These discounts and offers range from 10-25% off at area restaurants, businesses, and cell phone plans to open house events for staff, discount tickets to amusement parks in addition to field trip opportunities and course studies at area universities.

For a complete list of discounts and offers, please visit the District’s staff website at [https://staff-info.lsr7.org/discounts/](https://staff-info.lsr7.org/discounts/). **NOTE:** You will use your network login and password to log in.

Discounts, offers and various opportunities will be updated as they are received, so check back regularly to see how our business community is thanking you for all you do for our students!

Mileage Reimbursement

The District’s Mileage Reporting application is an on-line system designed for the reporting of mileage expenses by District employees. Applicable expenses include the following:

1. Mileage for building to building travel within the District.
2. Mileage for travel within the KC metropolitan area (60-mile radius of Lee’s Summit).

Step by step directions to the Mileage Reporting System can be found through the District’s Staff Website:

2. Click on Mileage, (located under Employee Apps).
3. Work through the site, following the on-line instructions.

All mileage is to be submitted for reimbursement during the current fiscal year at least once a month. Mileage for the month of June is the only expense eligible for reimbursement after the end of the current fiscal year, and will be reimbursed in July.

Mileage reimbursements are processed weekly and paid through direct deposit. You will receive notification through the District’s email system regarding pending reimbursement deposits.

For additional information, you may contact the District’s Business Services Specialist at (816) 986-1097.

Patient Protection Model Disclosure

The BCBS Blue Care HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBS of Kansas City at (888) 989-8842. You do not need prior authorization from BCBS of Kansas City or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBS of Kansas City at (888) 989-8842.
**Medicare Part D Notices**

**Important Notice From Reorganized School District No. 7 About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Reorganized School District No. 7 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. Reorganized School District No. 7 has determined that the prescription drug coverage that is part of each Blue KC plan option we sponsor is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and each 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 month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your coverage at Reorganized School District No. 7 through Blue KC will not be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance available at [http://www.cms.hhs.gov/CreditableCoverage/](http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

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

You should also know that if you drop or lose your current coverage with Blue KC through Reorganized School District No. 7 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 Your Options under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [http://www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [http://www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

<table>
<thead>
<tr>
<th>Date:</th>
<th>October 15, 2017</th>
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</thead>
<tbody>
<tr>
<td>Name of Entity/Sender:</td>
<td>Reorganized School District No.7</td>
</tr>
<tr>
<td>Contact-Position/Office:</td>
<td>Benefits Coordinator</td>
</tr>
<tr>
<td>Address:</td>
<td>301 NE Tudor Rd, Lee’s Summit MO 64066</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>(816)986-1000</td>
</tr>
</tbody>
</table>
Employee Rights and Responsibilities
Under the Family and Medical Leave Act (FMLA)

Basic Leave Entitlement

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

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee’s child after birth, or placement for adoption or foster care;
- to care for the employee’s spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12 week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12 month period.

A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

Benefits and Protections

During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles. *Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition

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

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

Use of Leave

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

Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

*The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”.*
Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days’ notice is not possible, the employee must provide notice as soon as practicable and employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified.

Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

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

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

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

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

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

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Women’s Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same copay, deductibles and/or coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, your applicable copay, deductibles and/or coinsurance will apply.

Women’s Health and Cancer Rights Act of 1998 Annual Notice

Did you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)?

If you would like more information on WHCRA benefits, call BCBS of KC at 816.943.2167 or 866.271.3850 (toll-free).

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)

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage.) This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding your or your dependents’ other coverage on your initial enrollment form/waiver.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You may also be eligible for a Special Enrollment Period if you and/or your dependents are determined to be eligible for premium assistance under a state Medicaid plan or state child health plan. You must request enrollment within 60 days of the date you are determined to be eligible for this premium assistance.
Wellness Program Notice

Inspiring Balance is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or “HRA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, blood pressure, glucose, and BMI. You can complete your biometric screening by seeing your personal physician or attending our annual onsite screenings offered annually. You are not required to complete the HRA or to complete a biometric screening.

However, when enhancement requirements are met, the prescription drug deductibles will be reduced to $150 for individuals and $450 for families on the Basic HMO, Buy-Up HMO, and PPO plans, and their annual/in-network deductibles will be reduced to $3,000 for individuals and $6,000 for families for the Qualified High Deductible Health Plans. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an enhancement, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative by contacting the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as voluntary District sponsored wellness programs as well as voluntary programs available via your BlueKC member portal. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information:

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lee’s Summit School District may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellness For Life will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are 1) the physician in your doctor’s office that performs your screening or 2) the nurse that administers your screening should you participate in our onsite screenings.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the District’s Business Services Department at (816) 986-1000 or by email at benefits@lsr7.net.

Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is being provided to you in response to Healthcare Reform mandates. This summary is in addition to the standard Blue Cross Blue Shield (Blue KC) benefit summary you are accustomed to and it is more general in nature. Your Blue KC benefit summary will provide more detail on your benefits and is available on the District’s website at: http://benefits.lsr7.org.

The SBC is available on the District’s website at: http://benefits.lsr7.org. For Blue KC members, it also available by accessing your member portal at www.bluekc.com. A paper copy is also available, free of charge, by calling the District’s Business Services Department at (816) 986-1000.
Eligible Expenses for Health Reimbursement Arrangement (HRA*), Health Savings Account (HSA) and Section 125 Medical Flexible Spending Account (FSA)

You can use money set aside in your Medical FSA, HRA* or HSA account for eligible medical expenses incurred by you, your spouse or your children. This includes diagnosis, treatment and prevention of disease or treatment for any part or function of the body. Cosmetic medical expenses, such as facelifts or hair removal, are not eligible. Expenses which benefit general health, such as vacation or health club memberships are also not eligible. Remember to keep your receipts and/or other documentation in case it is needed to verify the medical expense. Some items may require additional documentation such as a letter from your medical provider. Use the lists below for reference, but keep in mind these lists do not include all eligible/ineligible expenses. If you have questions about qualified medical expenses, visit www.irs.gov to view a complete list of qualified expenses.

- Adult Diapers
- Ambulance
- Athletic Care (ACE bandages, braces, etc.)
- Blood Pressure Monitors
- Catheters
- Chiropractic Treatments
- Contact Lenses, Solutions & Cleaners
- Contraceptives
- Corn & Callus Treatments (Foot Care)*
- Crutches
- Dental Treatment
- Denture Adhesives & Repair
- Denture Pain Relief & Cleaners
- Diabetes Testing, Diabetes Supplies
- Doctor’s Office Visits
- Ear Care Products
- Eyeglasses (Prescription & Reading)
- Eye Care Products
- First Aid Supplies*
- Glucosamine and/or Chondroitin
- Hearing Aids (and Batteries)
- Hospital Services
- Hot/Cold Therapy Packs
- Immunizations
- Incontinence Products*
- Infertility Treatments
- Nasal Sprays, Drops & Inhalers*
- Oral Treatments (Orajel, Mouth Sore Treatment, etc.)*
- Orthodontia
- Orthopedic Supports
- Over-the-counter medications with doctor’s prescription*
- Ovulation Kits
- Pap Smears
- Physical Therapy
- Prescription Drugs
- Prenatal Care (Vitamins*)
- Psychiatric/Psychologist Care
- Smoking Deterrents (Nicorette, etc.)
- Special Education Costs*
- Splints & Casts
- Thermometers
- Therapeutic Shoe Insoles*
- Transplants
- Vision Exams
- Wart Removers*
- Wheel Chairs
- X-ray Fees
* Requires a letter of medical necessity or a valid prescription

Health Savings Account Only Eligible Expenses

- COBRA premium
- Premium for certain Long Term Care policies (the premium for the District’s UNUM Long Term Care is not eligible)
- Health insurance premium if receiving unemployment

Ineligible Expenses for HRA, HSA and Section 125 Flexible Spending Accounts include, but are not limited to:

- Burial Expenses
- Cosmetic Procedures
- Dance Lessons
- Diapers
- Exercise Equipment (unless prescribed)
- Facelifts
- Fitness Programs
- Funeral Expenses
- Health Club Fees
- Household Help
- Illegal Treatments
- Insurance Premiums
- Items Covered by Insurance
- Marriage Counseling
- Maternity Clothes
- Nutritional Supplements
- Over-the-counter medicine without prescription
- Piercings
- Sunglasses (non-prescription)
- Swimming Lessons
- Tanning
- Teeth Whitening or Bleaching
- Toiletries (Toothbrush, Toothpaste, etc.)
- Vitamins (Over-the-Counter)
- Vacations
- Warranties (for Eyeglasses or Hearing Aids)
- Weight Loss Programs (unless prescribed)

*To be eligible for reimbursement of eligible medical expenses with HRA funds, spouse and children MUST be enrolled with you on you District medical plan.
How much should I contribute?
When deciding how much to set aside for next year’s medical expenses, think about the following:

- Does anyone in your family have any medical, dental or vision expenses that will not be covered by insurance?
- Does anyone in your family need prescription eyeglasses, contact lenses and contact solutions or cleaners?
- Is anyone in your family currently in orthodontics (braces) or do you expect anyone to begin treatment in the next year?
- Does anyone in your family have an ongoing illness that requires frequent doctor visits and/or medication?

Use this worksheet to help estimate your annual FSA or HSA election.

<table>
<thead>
<tr>
<th>Medical Expenses not covered by insurance</th>
<th>Current Year’s Out-of-Pocket Expenses ($)</th>
<th>Next Year’s Estimated Out-of-Pocket Expenses ($)</th>
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<tbody>
<tr>
<td>Annual Physical/Routine Exam</td>
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<tr>
<td>Copays/Coinsurance</td>
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<td>Deductibles</td>
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<td>Diabetic Supplies</td>
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<td>Immunizations (flu shots, etc.)</td>
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<tr>
<td>Laboratory Fees</td>
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<td>Maternity Expenses</td>
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<td>Over-the-Counter Drugs</td>
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<td>Prescription Drugs</td>
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<td>Psychiatric/Psychologist Fees</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Dental Expenses not covered by insurance</td>
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<td>Check Ups/Cleanings</td>
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<td>Copays/Coinsurance</td>
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<td>Crowns/Bridges/Dentures</td>
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<tr>
<td>Deductibles</td>
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<td>Fillings</td>
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<tr>
<td>Oral Surgery</td>
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<td>Orthodontia (braces)</td>
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<td>Root Canals</td>
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<td>Other:</td>
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<tr>
<td>Vision Expenses not covered by insurance</td>
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<tr>
<td>Contact Lenses</td>
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<tr>
<td>Contact Cleaners/Solutions</td>
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<tr>
<td>Copays/Coinsurance</td>
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<tr>
<td>Corrective Eye Surgery</td>
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<td>Deductibles</td>
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<td>Eye Exams</td>
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<td>Eyeglasses</td>
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<td>Other:</td>
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<td>Total Out-of-Pocket Medical Expenses:</td>
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<td><strong>$0.00</strong></td>
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</table>

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Resources At-A-Glance

Benefits and Wellbeing Coordinator
Sara McMillin
Lee’s Summit School District
Business Services Department
Phone: (816) 986-1048 | Fax: (816) 986-1561
Email: sara.mcmillin@lsr7.net

Benefits Specialist
Erin Jensen
Lee’s Summit School District
Business Services Department
Phone: (816) 986-1046 | Fax: (816) 986-1567
Email: erin.jensen@lsr7.net

Blue Cross and Blue Shield of Kansas City (Blue KC)
Customer Service Phone: (816) 395-2270
or (800) 654-0155
A Healthier You Program Phone: (816) 395-2121
Website: http://www.bluekc.com
Group Number: 23671000 (all plans)

CBIZ (District Insurance Consultant)
Maggie Releford
CBIZ Benefits & Insurance Services of Kansas City
700 West 47th Street, Suite 1100
Kansas City, MO 64112
Phone: (816) 945-5242
Email: mreleford@cbiz.com

CBIZ, Payroll (Retiree/COBRA benefits)
Theresa Brackens
CBIZ Payroll, Inc.
2797 Frontage Road, Suite 2000
Roanoke, VA 24017
Phone: (800) 815-3023, Option 6 | Fax: (800) 584-4223
Email: theresa.brackens@cbiz.com

Central Bank of the Midwest (Health Savings Accounts)
Sarah Giordano
Phone: (913) 791-9339
Website: https://www.centralbank.net
Email: sarah.giordano@centralbank.net

Complete Health & Wellness Center
600 NW Murray Road, Suite 103
Lee’s Summit, MO 64081
Phone: (877) 423-1330
Website: http://www.carehere.com

Cigna
Customer Service Phone: (800) 244-6224
Website: http://www.mycigna.com

Employee Assistance Program (EAP)
LifeMatters (Empathia, Inc.)
Customer Service Phone: (800) 634-6433
Website: https://www.mylifematters.com (Passcode: LSSD1)

Express Scripts (Pharmacy Mail Order)
Customer Service Phone: (888) 218-2579
Website: http://www.express-scripts.com

Nurse Line
BlueKC: Phone: (877) 852-5422
CareHere: Phone (877) 423-1330

Public School & Education Employee Retirement Systems of Missouri (PSRS/PEERS)
Customer Service Phone: (800) 392-6848
Website: http://www.psrsppeers.org

Surency Life and Health (FSA and HRA)
Customer Service Phone: (866) 818-8805
Website: http://www.surency.com

The Standard
Life and Waiver Phone: (800) 628-8600
Disability Phone: (800) 368-1135
Website: http://www.standard.com
Group Number Life Insurance Plans: 148497-A
Group Number Short Term Medical Leave Plan: 648787
Group Number Long Term Disability Plan: 148497-B

UNUM (Long Term Care)
Customer Service Phone: (913) 982-2300 or (800) 227-4165
Website: http://www.unumprovident.com
Group Number: 529058

VSP
Customer Service Phone: (800) 877-7195
Website: http://www.vsp.com
Group Number: 12100965

Workers’ Compensation
Charlie Minton
Lee’s Summit School District
Business Services Department
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