ANNUAL OPEN ENROLLMENT GUIDE

2017 Benefits for USD 259 Employees

November 7th—November 18th

Employee Benefits & Insurance Management  Phone (316) 973-4522  Fax (316) 973-4646  Email: employeebenefits@usd259.net
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The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Employee Benefits.
YOUR BENEFITS ENROLLMENT

Benefit Open Enrollment is the one opportunity each year that benefit-eligible employees have to make changes to their benefit elections. For example, employees may use this opportunity to add or remove a dependent to or from their medical plan, or elect a new benefit in which the employee was not previously enrolled.

Benefit changes made during Open Enrollment will take effect January 1, 2017 and will remain in effect through December 31, 2017, unless you have a qualifying event.

Mark Your Calendar
Your Open Enrollment Period for 2017 Benefits will be November 7, 2016—November 18, 2016

Introducing your new online benefits solution
Simple, personalized tools and information throughout the year

Your benefit decisions are important, and a lot goes into making the right choice. That’s why we’re introducing bswift, an easy-to-use, online benefits tool which provides a smart, simple and personalized enrollment experience to help you choose the plan that’s right for you.

You’ll find everything you need on bswift’s online portal. You can go there during enrollment and throughout the year to:

- Look up general benefits information
- Find important plan details
- Enroll in your benefits
- Make changes when you have qualifying life events
- Update life insurance beneficiaries
- View annual notices

Everything you need is online, anytime
WHAT’S NEW FOR 2017

Aetna Quality Point of Service (QPOS) Network (see page 14)

Requires each member and their covered dependents to designate an in-network Primary Care Physician (PCP) in order to enroll in the plan and receive the In-network level of benefits. Employees, spouses, and dependents will be required to designate an in-network primary care physician during open enrollment.
If you do not select a PCP during enrollment, Aetna will assign one to you.

Tiered Monthly Premiums (see pages 12 & 21)
USD 259 shares in the cost of coverage for this benefit.

There are four coverage levels available with each medical and dental plan:
* Employee only
* Employee + spouse
* Employee + child(ren)  same cost for one child or multiple children
* Family coverage  this would include spouse and child or children

Spouse Wellness Premium Discount (see page 18)
Spouses as well as employees on the health plan will each need to earn 100 wellness points between January 1, 2016 through December 31, 2016 in order to get the additional wellness premium discount starting January 2017.

Separation of Medical & Dental Plan Enrollment Elections
Employees will now be able to enroll in medical and dental coverage separately. An employee can be enrolled in medical only; dental only; or enroll in a medical and a dental plan.

New Benefit Plan ID Cards
You will receive new ID cards for medical, prescription drug, and dental coverage three to four weeks after enrollment. Aetna, Maxor, and Delta Dental will each have their own card.
ABOUT YOUR BENEFITS

Dependent Coverage and Time Limits

* Dependents must be added to or dropped from the Health Plan within 31 days of a life event (birth, marriage, divorce).
* Children up to age 26 can stay on the USD 259 health plan, regardless of student or marital status.
* During Open Enrollment, you can add or drop dependents.
* Dependent eligibility verification documents are required for any new dependents added to the plan.
* Social security numbers are required for all dependents.
* Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

Who can I Cover?

You may elect individual coverage for yourself or you may elect family coverage for yourself, your spouse and your eligible dependents under the district’s medical and dental plans.

You may cover the following eligible dependents:

* Your legal spouse
* Your eligible children under age 26 by birth, adoption, or legal guardianship, including eligible children of your spouse.
* Your eligible disabled child(ren) age 26 and over, including eligible disabled child(ren) of your spouse.

When to Enroll

The open enrollment period runs from November 7, 2016 through November 18, 2016.
YOUR OPEN ENROLLMENT CHECKLIST

Here’s a quick checklist to make it easier for you to navigate through Open Enrollment:

1. Read this guide and complete the planning worksheet for open enrollment.

2. Make sure you know your Employee ID number and your district network username and password.

3. Review the wellness credit matrix to verify you and your spouse have each earned 100 wellness points in order receive the $600 annual wellness premium discount for you and your spouse.

4. Visit Aetna’s online directory at www.aetna.com to find in-network primary care physicians (PCP) for each member of your family you plan to enroll into the health plan for 2017.

5. Collect any information to add new dependents, like their birth or marriage certificates and Social Security cards. (You will need to upload these when you enroll or fax these to Employee Benefits at 973-4646 when you enroll.

6. Review your receipts and other information from the past year, including your healthcare and dependent daycare expenses, so you can estimate next year’s expenses for your Flexible Spending Accounts.
FREE PREVENTATIVE SERVICES

ALL THREE (3) OF THE MEDICAL PLAN OPTIONS INCLUDE THE FOLLOWING FREE ANNUAL PREVENTATIVE CARE SERVICES AT IN-NETWORK PROVIDERS:

- Annual physical, including lab work, at in-network providers.
- One annual eye exam at in-network providers.
- Preventive colonoscopy at in-network providers.
- Free Adult Vaccines (CDC Recommended) at in-network providers
- One preventive annual Mammogram, Pap test and corresponding office visit per year, paid at 100% at in-network providers.
- One annual PSA test and corresponding office visit per year, paid at 100% at in-network providers.
- Well-Baby immunizations to age 19 and corresponding office visits, paid at 100%, at in-network providers.

CO-PAYS

ALL THREE (3) OF THE MEDICAL PLAN OPTIONS HAVE THE SAME CO-PAY AMOUNTS OUTLINED BELOW AT IN-NETWORK PROVIDERS:

**Office Visit Co-Pay (in-network):**

- Primary Care............... $ 30
- Specialist.................. $ 50

**Other Co-Pays (in-network):**

- Teladoc........................ $ 15
- Take Care / Little Clinic ..... $ 30
- Urgent Care.................... $ 50
- ER ......................... $ 100 Copay + Deductible & Coinsurance

**Rx Plan:**

- Generic drugs.......................... $10 co-pay
- Preferred brand drugs............... $30 co-pay
- Non-preferred brand drugs........... $55 co-pay
- Specialty.......................10% up to a max of $150
MENTAL HEALTH COVERAGE

If you are enrolled in any of the medical plans, Aetna offers help for mental health or substance abuse problems. The plan is administered by Aetna Behavioral Health. Anyone any age, gender, income, race or religion — can develop a behavioral health condition, like depression. These conditions are linked to brain functioning. And they can affect how someone thinks, feels and acts.

If you are coping with a behavioral health condition, there is good news! Your medical plan includes behavioral health benefits. That means we’re here with the help you need to work toward recovery, so you can get back to being your best.

Visit www.aetna.com and search “emotional health” to learn about various behavioral health conditions like depression and anxiety. You can take a confidential assessment or get a quick tip to improve your mood.

Not sure where to look for a mental health professional in your area? Visit www.aetna.com to find:
* Psychiatrists
* Psychologists
* Clinical social workers
* Clinical counselors
* Certified addiction counselors

Register for your secure member website at www.aetna.com, then log in to manage your benefits, claims and costs. “Ask Ann” is our virtual assistant on the website and she’s available 24/7 to provide help.

NEW DIRECTIONS

As part of the Mental Health Benefit, USD 259 offers an Employee Assistance Program (EAP) designed to assist employees in coping with personal problems that may impact their lives, behavior, or performance. These personal issues may be related to alcoholism, family problems, finances, marital conflicts, job loss, substance abuse, or stress related to job security and school crises.

The benefit provides short term counseling (6 visits) and referral services for employees and their household members. EAP services are provided in strict confidentiality. This benefit is provided by USD 259 at no cost to the employee. All USD 259 employees are automatically enrolled in this benefit and are eligible to utilize the EAP.

The EAP is provided through New Directions Behavioral Health. For additional information or to access services, visit www.ndbh.com, or call 1-800-624-5544.
The Prescription Drug Plan is designed to help keep medications affordable for you and your family. Your prescription drug benefit is included as part of your medical coverage and is administered by MaxorPlus, a pharmacy benefits manager. When you enroll in medical coverage, you will receive a Maxor Plus ID card and information on locating a pharmacy near you.

Most major pharmacy chains accept MaxorPlus. Present your MaxorPlus ID card when filling prescriptions. You can save money on medications you take on a long-term basis by using mail order with Maxor. With Maxor mail order, you can buy up to a 90-day supply at a reduced copayment when compared to retail pharmacies.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retail Co-pay (30 Day Supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$55</td>
</tr>
<tr>
<td>Specialty</td>
<td>10% up to $100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mail Order Co-pay (90 Day Supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$60</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$110</td>
</tr>
<tr>
<td>Specialty</td>
<td>N/A</td>
</tr>
</tbody>
</table>

FREE MEDICATIONS

Formulary Generic blood pressure, cholesterol, and select diabetic medications and supplies are free at any in-network pharmacy. Please talk to your doctor about prescribing a generic so you can save money.

For additional benefits on oral diabetic medication and formulary insulin, contact Employee Benefits at 316-973-4564, to inquire about the Dillon’s Diabetic Coaching Program.

We’re Here to Help

If you have questions, please call our customer service department at 1-800-687-0707. Representatives are available to assist Monday through Friday 7AM-9PM, Saturday 8AM-6PM, and Sunday 9AM-5PM CST (Central Standard Time). In the event of an emergency, MaxorPlus has staff readily available 24/7 to assist you with your prescription benefit questions.
TELADOC

MEET OUR DOCTORS
Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:
- Are practicing PCPs, pediatricians, and family medicine physicians
- Have average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED
Teladoc doctors can treat many medical conditions, including:
- Cold & flu symptoms
- Allergies
- Sinus problems
- Ear infection
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

WHEN CAN I USE TELADOC?
Teladoc does not replace your primary physician. It is a convenient and affordable option for quality care:
- When you need care now
- If you’re considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for $15

STEP 1
SET UP YOUR ACCOUNT
We’ve made it quick and easy to set up your account online. Simply visit the website and click “Set up account”.

STEP 2
UPDATE YOUR MEDICAL HISTORY
Make sure the “My Medical History” tab is updated so the doctor has the information needed to provide an accurate diagnosis.

STEP 3
REQUEST A CONSULT
Teladoc doctors are available when you need care now. Request a consult anytime online or by phone.

Teladoc.com/Aetna
Facebook.com/Teladoc
1-855-Teladoc (835-2362)
Teladoc.com/mobile
When you are enrolled in our medical plan, you also receive vision benefits. If you utilize the services of a provider listed in the Preferred Provider Directory, your benefits include one annual routine vision exam with a $0 copay, and preferred pricing on a large selection of brand-name, designer frames, lenses, and lens option.

Vision Savings Snapshot
Keep this chart handy - it's a listing of savings available to you.

<table>
<thead>
<tr>
<th>Product or Service</th>
<th>Reduced Fee/member Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frames</strong></td>
<td></td>
</tr>
<tr>
<td>Eyeglass Frames (retail prices)</td>
<td>35% off retail prices</td>
</tr>
<tr>
<td><strong>Lenses per Pair (uncoated plastic)</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$40.00</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$60.00</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$80.00</td>
</tr>
<tr>
<td>Standard Progressive (no-line bifocal)</td>
<td>$120.00</td>
</tr>
<tr>
<td><strong>Lens Options per Pair (add to lens price above)</strong></td>
<td></td>
</tr>
<tr>
<td>Standard Polycarbonate (includes UV and scratch-resistant coating)</td>
<td>$40.00</td>
</tr>
<tr>
<td>Scratch-resistant coating</td>
<td>$15.00</td>
</tr>
<tr>
<td>Ultraviolet (UV) coating</td>
<td>$15.00</td>
</tr>
<tr>
<td>Solid or gradient tint</td>
<td>$15</td>
</tr>
<tr>
<td>Glass</td>
<td>20% off retail</td>
</tr>
<tr>
<td>Photochromic for glass</td>
<td>20% off retail</td>
</tr>
<tr>
<td>Standard anti-reflective coating</td>
<td>$45.00</td>
</tr>
<tr>
<td><strong>Eye Exams for Plans That Do Not Cover Eye Exams</strong></td>
<td></td>
</tr>
<tr>
<td>For eyeglasses</td>
<td>$42.00</td>
</tr>
<tr>
<td>For standard contact lenses fit &amp; follow up</td>
<td>$40.00 (plus $42 exam fee)</td>
</tr>
<tr>
<td>For specialty contact lenses (that is, Toric, Bifocal, Gas Permeable) fit and follow-up</td>
<td>$10 off standard fee (plus $42 exam fee)</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Conventional (non-disposable) lenses</td>
<td>15% discount** off retail prices</td>
</tr>
<tr>
<td><strong>Additional Vision-Related Items</strong></td>
<td></td>
</tr>
<tr>
<td>All Other</td>
<td>20% discount on retail prices</td>
</tr>
<tr>
<td>LASIK procedures</td>
<td>15% off standard prices or 5% off promotional prices for LASIK services obtained through the U.S. Laser Network. Member must call before scheduling an appointment.</td>
</tr>
</tbody>
</table>

*EyeMed Services and Compensation Schedule, 1/15. Prices are subject to change. **Discount does not apply to disposable contact lenses.

Find a participating provider
- Visit www.aetna.com or call 1-800-793-8616 (Mon-Sat, 8 a.m. to 11 p.m. ET and Sun. 11 a.m. to 8 p.m. ET) to find a participating provider.
# MEDICAL PLAN PREMIUMS

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Employee Monthly Cost</th>
<th>Employee Monthly Cost</th>
<th>BOE Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Wellness Discount</td>
<td>Without Wellness Discount</td>
<td></td>
</tr>
<tr>
<td>Medical Base Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$0</td>
<td>$50.00</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$0</td>
<td>One without = $50.00 Both without = $100.00</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$0</td>
<td>$50.00</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$0</td>
<td>One without = $50.00 Both without = $100.00</td>
<td>$690</td>
</tr>
<tr>
<td>Medical Buy Up Plan – Option 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$55.52</td>
<td>$105.52</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$116.58</td>
<td>One without = $166.58 Both without = $216.58</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$105.47</td>
<td>$155.47</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$172.10</td>
<td>One without = $222.10 Both without = $272.10</td>
<td>$690</td>
</tr>
<tr>
<td>Medical Buy Up Plan – Option 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$38.71</td>
<td>$88.71</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$81.27</td>
<td>One without = $131.27 Both without = $181.27</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$73.54</td>
<td>$123.54</td>
<td>$690</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$120.00</td>
<td>One without = $170.00 Both without = $220.00</td>
<td>$690</td>
</tr>
</tbody>
</table>

*Actual monthly premium can vary based on the employees specific pay calendar.*
## MEDICAL PLAN COMPARISONS

<table>
<thead>
<tr>
<th></th>
<th>Base Plan</th>
<th>Premium Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Option 1</td>
<td>Option 2</td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$4,500</td>
<td>$1,500</td>
<td>$2,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$9,000</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$9,000</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$18,000</td>
<td>$6,000</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>70/30</td>
<td>70/30</td>
<td>70/30</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>50/50</td>
<td>50/50</td>
<td>50/50</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximums</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical—Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$6,150</td>
<td>$4,500</td>
<td>$6,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$12,300</td>
<td>$9,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Medical—Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$12,300</td>
<td>$9,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$24,600</td>
<td>$18,000</td>
<td>$24,000</td>
</tr>
<tr>
<td>Prescription—Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$1,000</td>
<td>$2,650</td>
<td>$1,150</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prescription—Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$2,000</td>
<td>$5,300</td>
<td>$2,300</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
YOUR NEW QPOS MEDICAL PLAN

Quality Point-of-Service® (QPOS®) Plan

All employees will be required to select a primary care physician (PCP) for every member enrolled in the health plan. Selecting a primary care physician (PCP) is important. Why? PCPs do more than give you a checkup. They know you and your medical history. They can help guide you on important health decisions and direct your care. Plus, when you choose a PCP, you can pay less out of pocket, obtain referrals to a specialist and get the most out of your plan.

Visiting a physician that is not your designated PCP or seeing a specialist without a referral from your designated PCP will increase your out-of-pocket expenses.

<table>
<thead>
<tr>
<th>Your options</th>
<th>Pick your doctor</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP option</strong></td>
<td>Choose a PCP in our network for your primary care. This could be a pediatrician for your kids. Other types of PCPs include family practice and internal medicine doctors.</td>
<td>Your PCP will get approval from us before providing some services and file claims for you.</td>
</tr>
<tr>
<td><strong>When you visit your PCP, you may:</strong></td>
<td></td>
<td>• Pay a <strong>copay</strong>. This is a set dollar amount you pay for a covered health care service. If your copay is $30, you pay that amount when you go to your doctor. • Meet a <strong>deductible</strong>. This is the amount you pay before the plan begins to pay its share of the cost.</td>
</tr>
<tr>
<td><strong>Network option</strong></td>
<td>Visit any other network doctor, including a specialist. You will need a referral from your PCP to see a specialist at the network cost level.</td>
<td>Your network doctor will get approvals and file claims for you.</td>
</tr>
<tr>
<td><strong>You may:</strong></td>
<td></td>
<td>• Pay a yearly deductible. • Pay <strong>coinsurance</strong>. This is your share of the cost of a covered health care service. You pay a percent, and your health plan pays a percent. Like 30%/70%.</td>
</tr>
<tr>
<td><strong>Out-of-network option</strong></td>
<td>Go to any licensed doctor or specialist. You don’t have to stay in network — or get referrals.</td>
<td>Your may have to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Get approval from us before receiving some services • File your own claims • Pay the difference between the amount paid by your plan and the amount charged by your doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You will pay a yearly deductible, too.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>You typically pay more for care with this option.</strong></td>
</tr>
</tbody>
</table>

Finding a PCP or network doctor is easy

Use Aetna’s online directory. You can find doctors by name, specialty and location. You’ll also find maps, directions and more. You can even look for doctors who speak a foreign language. Try it out at www.aetna.com.
USD 259 Health Plan At A Glance (Base Plan Medical)

**JANUARY-DECEMBER 2017**

Employee Annual Cost (0.75 - 1.0 FTE only) w/Wellness Waiver

Health Plan **
- Employee Only: $0
- Employee + Child(ren): $0
- Employee + Spouse: $0
- Family: $0

**The employee + spouse can each earn a $600 annual wellness premium waiver by each accumulating 100 wellness credits between January and December 2016.**

Employee Monthly Cost
- Working spouse add: $200
- Employee tobacco-user add: $100
- Spouse tobacco-user add: $100
- Part-Time Premium add: $40

**Actual monthly premium can vary depending on employees specific pay calendar.**

**Part-time premium for permanent employees 0.75-0.99 FTE.**

Office Visit Co-Pay (in-network):
- Primary Care (PCP) is required: $30
- Specialist: $50

(Office visit co-pay is in lieu of deductible/coinsurance for routine health visits and minor acute illness visits.)

Other Co-Pays (in-network):
- Teladoc (24/7/365 Physician telephone consult): $30
- Urgent / Immediate Care: $50
- ER: $100
- High Tech Radiology: $100

(Deductible and Co-Inurance will also apply to ER & High Tech Radiology. Prior authorization required for High Tech Radiology)

Deductibles

Health Plan (in-network)
- Individual: $4,500
- Family: $9,000

Health Plan (out-of-network)
- Individual: $9,000
- Family: $18,000

Co-Insurance

Health Plan
- In-Network: 70/30
- Out-of-Network: 50/50

Out-of-Pocket Maximum

Health Plan (annual in network)
- Individual: $6,150
- Family: $12,300

Health Plan (annual out-of-network)
- Individual: $12,300
- Family: $24,600

Prescriptions (in-network only)
- Individual: $1,000
- Family: $2,000

(Prescription co-pays will accumulate towards the out-of-pocket maximum.)


Rx Plan: $10 for generic, $30 for formulary and $55 for non-formulary; 10% co-pay for self-administered injectable (max $100) per script.

Vision Exam Co-Pay (annual in-network): $0

**NEW FOR 2017**

- Separation of medical and dental plan enrollment
- Tiered Premium Rates
- Both the employee and spouse on the health plan will each need to earn 100 wellness points to get the $600 premium waiver
- Designation of primary care physician (PCP) required during enrollment
- Unlimited Nutrition Counseling visits at in-network provider

**FREE ANNUAL PREVENTIVE CARE AT IN-NETWORK PROVIDERS**

- Annual physical, including lab work, at in-network providers.
- One preventive annual Mammogram, Pap test and corresponding office visit per year paid at 100% at in-network providers.
- One annual PSA test and corresponding office visit paid at 100% at in-network providers.
- Well-Baby immunizations to age 19 and corresponding office visits paid at 100%, at in-network providers.
- Preventive colonoscopy starting at age 50 at in-network providers.
- Free Adult Vaccines (CDC Recommended) at in-network providers

**FREE MEDICATIONS**

Formulary Generic blood pressure, cholesterol, and select diabetic medications and supplies are free at any in-network pharmacy. Please talk to your doctor about prescribing a generic so you can save money.

For additional benefits on oral diabetic medication and formulary insulin, contact Employee Benefits at 316-973-4564 to inquire about the Dillon’s Diabetic Coaching Program.

**DEPENDENT COVERAGE**

Dependents must be added to or dropped from the Health Plan within 31 days of a life event (birth, adoption, marriage, divorce, loss or gain of outside coverage etc.). If over 31 days, you will not be able to add/drop a dependent until the next open enrollment period with changes effective the following January.

Dependents up to age 26 can stay on the USD 259 health plan regardless of student or marital status.

During Open Enrollment you can add or drop dependents. Dependent eligibility verification documents are required for any new dependents added to the plan.

Social Security numbers are required for all dependents. Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

For assistance with medical benefits contact:
- Aetna Customer Service 800-228-6481
- Aetna Behavioral Health 800-424-4047

For assistance with prescription benefits contact:
- MaxorPlus at 800-687-0707
- MaxorPlus Mail Order 800-687-8629
- MaxorPlus Specialty Pharmacy 866-629-6779

Pharmacy PCN: 10000019  BIN#: 005377

For assistance with our Employee Assistance Program contact:
- New Directions at 800-624-5544 or www.ndbh.com

Questions about your Health Plan? Contact Employee Benefits at employeebenefits@usd259.net or call 973-4581.
# JANUARY-DECEMBER 2017

**Employee Monthly Cost (0.75 - 1.0 FTE only) w/ Wellness Waiver**

Health Plan **

- Employee Only ............................................. $55.52
- Employee + Child(ren) ................................. $105.47
- Employee + Spouse ...................................... $116.58
- Family ....................................................... $172.10

**The employee + spouse can each earn a $600 annual wellness premium waiver by each accumulating 100 wellness credits between January and December 2016.**

**Employee Monthly Cost**

+ Working spouse add...................................... $200
+ Employee tobacco-user add ............................. $100
+ Spouse tobacco-user add ............................... $100
+ Part-Time Premium add ................................. $40

**Actual monthly premium can vary depending on employees specific pay calendar.**

**Part-time premium for permanent employees 0.75—0.99 FTE.**

**Office Visit Co-Pay (in-network):**

- Primary Care (PCP is required) .......................... $30
- Specialist ...................................................... $50

(Office visit co-pay is in lieu of deductible/coinsurance for routine health visits and minor acute illness visits.)

**Other Co-Pays (in-network):**

- Teladoc (24/7/365 Physician telephone consult) ....... $15
- Walgreens Take Care / Dillons Little Clinic .......... $30
- Urgent / Immediate Care ................................. $50
- ER ..................................................................... $100
- High Tech Radiology ...................................... $100

(Deductible and Co-Insurance will also apply to ER & High Tech Radiology. Prior authorization required for High Tech Radiology)

**Deductibles**

**Health Plan (in-network):**

- Individual .................................................. $1,500
- Family ....................................................... $3,000

**Health Plan (out-of-network):**

- Individual .................................................. $3,000
- Family ....................................................... $6,000

**Co-Insurance**

- Health Plan
  - In-Network ............................................... 70/30
  - Out-of-Network ......................................... 50/50

**Out-of-Pocket Maximum**

- Health Plan (annual in network) .................. $4,500
  - Family .................................................... $9,000
- Health Plan (annual out-of-network) .......... $9,000
  - Family .................................................... $18,000

**Prescriptions (in-network only):**

- Individual .................................................. $2,650
- Family ...................................................... $5,300

(Prescription co-pays will accumulate towards the out-of-pocket maximum.)

**Before going out-of-network, call Aetna Customer Service to determine out-of-network costs and learn about in-network alternatives.**

**Rx Plan:**
- $10 for generic,
- $30 for formulary
- $55 for non-formulary
- 10% co-pay for self-administered injectable (max $100) per script.

**Vision Exam Co-Pay (annual in-network):**

- $0

---

# NEW FOR 2017

- Separation of medical and dental plan enrollment
- Tiered Premium Rates
- Both the employee and spouse on the health plan will each need to earn 100 wellness points to get the $600 premium waiver
- Designation of primary care physician (PCP) required during enrollment
- Unlimited Nutrition Counseling visits at in-network provider

### FREE ANNUAL PREVENTIVE CARE AT IN-NETWORK PROVIDERS

- Annual physical, including lab work, at in-network providers.
- One preventive annual Mammogram, Pap test and corresponding office visit per year paid at 100% at in-network providers.
- One annual PSA test and corresponding office visit per year paid at 100% at in-network providers.
- Well-Baby immunizations to age 19 and corresponding office visits paid at 100%, at in-network providers.
- One annual eye exam at in-network providers.
- Preventive colonoscopy starting at age 50 at in-network providers.
- Free Adult Vaccines (CDC Recommended) at in-network providers

### FREE MEDICATIONS

Formulary Generic blood pressure, cholesterol, and select diabetic medications and supplies are free at any in-network pharmacy. Please talk to your doctor about prescribing a generic so you can save money.

For additional benefits on oral diabetic medication and formulary insulin, contact Employee Benefits at 316-973-4564 to inquire about the Dillons Diabetic Coaching Program.

### DEPENDENT COVERAGE

Dependents must be added to or dropped from the Health Plan within 31 days of a life event (birth, adoption, marriage, divorce, loss or gain of outside coverage etc.). If over 31 days, you will not be able to add/drop a dependent until the next open enrollment period with changes effective the following January.

Dependents up to age 26 can stay on the USD 259 health plan regardless of student or marital status.

During Open Enrollment you can add or drop dependents. Dependent eligibility verification documents are required for any new dependents added to the plan.

Social Security numbers are required for all dependents. Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

For assistance with medical benefits contact:

**Aetna Customer Service** 800-228-6481

**Aetna Behavioral Health** 800-424-4047

For assistance with prescription benefits contact:

**MaxorPlus at 800-687-0707**

**MaxorPlus Mail Order 800-687-8629**

**MaxorPlus Specialty Pharmacy 866-629-6779**

Pharmacy PCN: 10000019  BIN#: 005377

For assistance with our Employee Assistance Program contact:

**New Directions** at 800-624-5544 or www.ndth.com

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Questions about your Health Plan? Contact Employee Benefits at employeebenefits@usd259.net or call 973-4581.
### USD 259 Health Plan At A Glance (Premium Plan Option 2 Medical)

#### JANUARY-DECEMBER 2017

**Employee Monthly Cost (0.75 - 1.0 FTE only) w/Wellness Waiver**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family (1-2 persons)</th>
<th>Family (3 or more persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan (in-network)</td>
<td>$2,000</td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Health Plan (out-of-network)</td>
<td>$4,000</td>
<td>$8,000</td>
<td></td>
</tr>
</tbody>
</table>

**Other Co-Pays (in-network):**

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teladoc (24/7/365 Physician telephone consult)</td>
<td>$15</td>
</tr>
<tr>
<td>Walgreens Take Care / Dillons Little Clinic</td>
<td>$30</td>
</tr>
<tr>
<td>Urgent / Immediate Care</td>
<td>$50</td>
</tr>
<tr>
<td>ER</td>
<td>$100</td>
</tr>
<tr>
<td>High Tech Radiology</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Deductibles:**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Individual</th>
<th>Family (1-2 persons)</th>
<th>Family (3 or more persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan (in-network)</td>
<td>$2,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Plan (out-of-network)</td>
<td>$4,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Individual</th>
<th>Family (1-2 persons)</th>
<th>Family (3 or more persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan (annual in-network)</td>
<td>$6,000</td>
<td>$12,000</td>
<td></td>
</tr>
<tr>
<td>Health Plan (annual out-of-network)</td>
<td>$12,000</td>
<td>$24,000</td>
<td></td>
</tr>
</tbody>
</table>

**Prescriptions (in-network only):**

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,150</td>
</tr>
<tr>
<td>Family</td>
<td>$2,300</td>
</tr>
</tbody>
</table>

**Vision Exam Co-Pay (annual in-network):**

- $0

**NEW FOR 2017**

- Separation of medical and dental plan enrollment
- Tiered Premium Rates
- Both the employee and spouse on the health plan will each need to earn 100 wellness points to get the $600 premium waiver
- Designation of primary care physician (PCP) required during enrollment
- Unlimited Nutrition Counseling visits at in-network provider

### FREE ANNUAL PREVENTIVE CARE AT IN-NETWORK PROVIDERS

- Annual physical, including lab work, at in-network providers.
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- One annual PSA test and corresponding office visit per year paid at 100%, at in-network providers.
- Well-Baby immunizations to age 19 and corresponding office visits paid at 100%, at in-network providers.
- One annual eye exam at in-network providers.
- Preventive colonoscopy starting at age 50 at-in-network providers.
- Free Adult Vaccines (CDC Recommended) at in-network providers

### FREE MEDICATIONS

- Formulary Generic blood pressure, cholesterol, and select diabetic medications and supplies are free at any in-network pharmacy. Please talk to your doctor about prescribing a generic so you can save money.

For additional benefits on oral diabetic medication and formulary insulin, contact Employee Benefits at 316-973-4564 to inquire about the Dillon’s Diabetic Counseling Program.

### DEPENDENT COVERAGE

Dependents must be added to or dropped from the Health Plan within 31 days of a life event (birth, adoption, marriage, divorce, loss or gain of outside coverage etc.). If over 31 days, you will not be able to add/drop a dependent until the next open enrollment period with changes effective the following January.

Dependents up to age 26 can stay on the USD 259 health plan regardless of student or marital status.

During Open Enrollment you can add or drop dependents. Dependent eligibility verification documents are required for any new dependents added to the plan.

Social Security numbers are required for all dependents. Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

**For assistance with medical benefits contact:**
- Aetna Customer Service 800-228-6481
- Aetna Behavioral Health 800-424-4047

**For assistance with prescription benefits contact:**
- MaxorPlus at 800-687-0707
- MaxorPlus Mail Order 800-687-8629
- MaxorPlus Specialty Pharmacy 866-629-6779
- Pharmacy PCN: 10000019 BIN#: 005377

**For assistance with our Employee Assistance Program contact:**
- New Directions at 800-624-5544 or www.ndh.com
SAVING YOU MONEY ON HEALTHCARE

**ALL** employees and spouses who wish to enroll in the health plan will be required to have their wellness items verified in order to receive the wellness premium discount. Members may be required to upload supporting documentation as necessary, of the wellness initiatives completed when enrolling in benefits for the 2017 plan year.

If you and/or your spouse each complete 100 wellness points before the December 31, 2016 deadline, you will pay $1,200 less for your medical premiums in 2017!

**Wellness Credit Verification:** You will only need to submit documentation of points not already verified on your behalf by Aetna, Delta Dental and Maxor. If you and/or your spouse have appointments still pending for 2016 you may upload a copy of your appointment card during open enrollment as pre-verification of those pending wellness points.

### WELLNESS CREDITS

**2016 Activities For 2017 Health Plan Premium Waiver**

for Employees & Spouses on the Health Plan

<table>
<thead>
<tr>
<th>40 POINTS EACH</th>
<th>25 POINTS EACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Annual Physical including blood work</td>
<td>- Well-Woman Mammogram</td>
</tr>
<tr>
<td>- Annual Eye Exam</td>
<td>- Well-Woman Pap Test</td>
</tr>
<tr>
<td>- Dental Cleanings two times per year</td>
<td>- Well-Man PSA Test</td>
</tr>
<tr>
<td></td>
<td>- Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>- Annual Flu Shot or Approved CDC Vaccine</td>
</tr>
<tr>
<td></td>
<td>- Non-Tobacco / Nicotine User</td>
</tr>
<tr>
<td></td>
<td>Subject to audit and confirmation testing.</td>
</tr>
<tr>
<td></td>
<td>* For assistance in stopping the use of tobacco, you may contact the Kansas Tobacco Quitline at 1-800-QUIT-NOW</td>
</tr>
<tr>
<td></td>
<td>* Nicotine gum/patches are not considered tobacco products if prescribed or recommended by a physician and/or used in conjunction with smoking cessation treatment.</td>
</tr>
</tbody>
</table>

Please Note: Your Health Plan is committed to helping you achieve your best health. The premium waiver for participating in the wellness program is available to all employees. If you think you might be unable to meet the standard for a waiver under this wellness program, you might qualify for an opportunity to earn the same waiver by different means. Contact Employee Benefits at 973-4581 and we will work with you (and if you wish, with your doctor) to find a wellness program for the same waiver that is right for you in light of your health status.

Earn a $600 annual premium waiver by accumulating 100 wellness points between January and December 2016

*NEW: Spouses on the health plan will also need to accumulate 100 wellness points between January and December 2016 to earn the $600 annual premium waiver.*
## ADDITIONAL EMPLOYEE PAID PREMIUMS

<table>
<thead>
<tr>
<th></th>
<th>Bi-weekly 26 pays</th>
<th>Bi-weekly 20 pays</th>
<th>Monthly</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Spouse</td>
<td>$92.31</td>
<td>$120</td>
<td>$200</td>
<td>$2,400</td>
</tr>
<tr>
<td>Employee tobacco user</td>
<td>$46.15</td>
<td>$60</td>
<td>$100</td>
<td>$1,200</td>
</tr>
<tr>
<td>Spouse tobacco user</td>
<td>$46.15</td>
<td>$60</td>
<td>$100</td>
<td>$1,200</td>
</tr>
<tr>
<td>Part Time Premium</td>
<td>$18.46</td>
<td>$24</td>
<td>$ 40</td>
<td>$ 480</td>
</tr>
<tr>
<td>Employee w/o Wellness</td>
<td>$23.08</td>
<td>$30</td>
<td>$ 50</td>
<td>$ 600</td>
</tr>
<tr>
<td>Spouse w/o Wellness</td>
<td>$23.08</td>
<td>$30</td>
<td>$ 50</td>
<td>$ 600</td>
</tr>
</tbody>
</table>

## OTHER COVERAGE OPTIONS

### MINIMUM VALUE PLAN

To be in compliance with the ACA, the district offers a minimum value high deductible plan to eligible non-benefitted employees. The Minimum Value Health Plan (MVP) is also available to benefitted employees and health plan eligible retirees.

**About the MVP:**
- No PCP requirement.
- No dental coverage options offered with election of this plan.
- Spouses are not eligible to be covered under this plan.
- This plan will have an individual medical deductible of $5,850.

### CASH OPTION

Eligible employees who provide evidence of other medical coverage during online open enrollment may select a cash option of $100 per month in lieu of the Board provided group plan.

Dual employees of USD 259 are also eligible for the cash option if the health plan enrollment is under the spouse. One elects cash option, and the spouse enrolls both on the plan.
# USD 259 Health Plan At A Glance (MVP PLAN)

## JANUARY-DECEMBER 2017

**Employee Cost**

- Monthly Health Plan (Employee only) .................. $145.23
- Monthly Health Plan (Employee + Child) .............. $434.81
- Monthly Employee Tobacco-User add .................. $100.00
  
  *This plan does not provide spousal coverage*

**Office Visit (in-network):**

- Primary Care - Covered at 100% after deductible
- Specialist - Covered at 100% after deductible
- Urgent / Immediate Care - Covered at 100% after deductible

**Hospital Services (in-network):**

- Emergency Room - Covered at 100% after deductible
- Outpatient Hospital - Covered at 100% after deductible
- Inpatient Hospital - Covered at 100% after deductible
- Outpatient Surgery - Covered at 100% after deductible

**Diagnostic Services (in-network):**

- Diagnostic X-ray - Covered at 100% after deductible
- Diagnostic Laboratory - Covered at 100% after deductible

**Mental Health Services:**

- Covered at 100% after deductible

**Deductibles (annual in-network):**

(Unless otherwise indicated, the deductible must be met prior to benefits being payable)

**Medical**

- Individual.............................................. $5850
- Family...................................................... $11,700

**Prescription**

- Individual.............................................. $1000
- Family...................................................... $2000

**Out-of-Pocket Maximum (annual in-network):**

**Medical**

- Individual.............................................. $5,850
- Family...................................................... $11,700

**Prescriptions**

- Individual.............................................. $1,000
- Family...................................................... $2,000

**Combined Medical + Prescription**

- Individual.............................................. $6,850
- Family...................................................... $13,700

*There are no benefits for out-of-network services unless medical emergency*

**Lifetime Health Plan Maximum:**

- None

**FREE ANNUAL PREVENTIVE CARE AT IN-NETWORK PROVIDERS**

- One preventive eye exam per 24 months
- One preventive Adult Physical Exam
- One preventive Mammogram for females age 40 and over, Pap test and corresponding office visit paid at 100%
- One annual PSA and corresponding office visit paid at 100% for males 40 and over
- Well-Child Exams to age 22
- Preventive colonoscopy starting at age 50
- Adult Vaccines (CDC Recommended)

**DEPENDENT COVERAGE**

Dependents must be added to or dropped from the Health Plan within 31 days of a life event (birth, adoption, marriage, divorce, loss or gain of outside coverage etc.). If over 31 days, you will not be able to add/drop a dependent until the next open enrollment period with changes effective the following January.

Dependents up to age 26 can stay on the USD 259 health plan regardless of student or marital status.

During Open Enrollment you can add or drop dependents. Dependent eligibility verification is required for any new dependents to be added to the plan.

Social Security numbers are required for all dependents. Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

**For assistance with medical benefits contact:**
Aetna Customer Service 800-229-6481
Aetna Behavioral Health 800-424-4047

**For assistance with prescription benefits contact:**
MaxorPlus at 800-687-0707
MaxorPlus Mail Order 800-687-8629
MaxorPlus Specialty Pharmacy 866-629-6779

Pharmacy PCN: 10000019 BIN#: 005377

**For assistance with our Employee Assistance Program contact:**
New Directions at 800-624-5544 or www.ndbh.com

**For more information about your health plan, see the Summary Plan Description on the Employee Benefits webpage or contact Aetna Customer Service at 1-800-229-6481.**

---

**Dental:**

- This plan does not provide dental benefits
# DENTAL PLAN COVERAGE

## Deductible (The amount you must pay before the plan begins paying benefits for non-preventive care.)

<table>
<thead>
<tr>
<th></th>
<th>BASE PLAN</th>
<th>PREMIUM PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$150</td>
</tr>
</tbody>
</table>

## You pay

<table>
<thead>
<tr>
<th>Service Description</th>
<th>BASE PLAN</th>
<th>PREMIUM PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive (cleanings, oral exams)</td>
<td>$0, no deductible</td>
<td>$0, no deductible</td>
</tr>
<tr>
<td>Basic/Restorative (fillings)</td>
<td>Not covered</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Major (bridges, dentures)</td>
<td>Not covered</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Annual maximum (The most the plan will pay in a calendar year.)

<table>
<thead>
<tr>
<th></th>
<th>BASE PLAN</th>
<th>PREMIUM PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Person</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

## Limited Lifetime Implant Coverage (Prior authorization required for implants)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>BASE PLAN</th>
<th>PREMIUM PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant Coverage</td>
<td>Not covered</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

---

## DENTAL PLAN MONTHLY PREMIUMS

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Base Dental</th>
<th>Premium Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$0</td>
<td>$15.82</td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>$0</td>
<td>$33.22</td>
</tr>
<tr>
<td>Employee + child(ren)</td>
<td>$0</td>
<td>$30.05</td>
</tr>
<tr>
<td>Employee + family</td>
<td>$0</td>
<td>$49.04</td>
</tr>
</tbody>
</table>

*Actual monthly premium can vary based on the employee's specific pay calendar.
FLEXIBLE SPENDING ACCOUNTS

Health Care and Dependent Care Flexible Spending Accounts

Wichita Public Schools provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll / re-enroll in the plan to participate for the plan year January 1 to December 31, 2017.

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don’t pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. The maximum amount you can contribute to the Health Care Flexible Spending Account is set by your employer.

The maximum amount you can contribute to the Dependent Care Flexible Spending Account is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately.

The following example shows how you can save money with a flexible spending account.

Bob and Jane’s combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,300 for day care next plan year. They decide to direct a total of $5,300 into their FSAs.

<table>
<thead>
<tr>
<th>Without FSAs</th>
<th>With FSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income:</td>
<td>$30,000</td>
</tr>
<tr>
<td>FSA contributions:</td>
<td>0</td>
</tr>
<tr>
<td>Gross income:</td>
<td>30,000</td>
</tr>
<tr>
<td>Estimated taxes:</td>
<td></td>
</tr>
<tr>
<td>Federal</td>
<td>-2,550*</td>
</tr>
<tr>
<td>State</td>
<td>-900**</td>
</tr>
<tr>
<td>FICA</td>
<td>-2,295</td>
</tr>
<tr>
<td>After-tax earnings:</td>
<td>24,255</td>
</tr>
<tr>
<td>Eligible out-of-pocket</td>
<td></td>
</tr>
<tr>
<td>Medical and dependent care expenses:</td>
<td>-5,000</td>
</tr>
<tr>
<td>Remaining spendable income:</td>
<td>$19,255</td>
</tr>
<tr>
<td>Spendable income increase:</td>
<td>$1,306</td>
</tr>
</tbody>
</table>

*Assumes standard deductions and four exemptions.
** Varies, assume 3 percent.

The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.
Summary of Dental Plan Benefits
WICHITA PUBLIC SCHOOLS (BASE PLAN)
Group #92703
Effective for January 1, 2017

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

Benefit % Paid

<table>
<thead>
<tr>
<th>Delta Dental</th>
<th>Delta Dental</th>
<th>Non-Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>Premier</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>70%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Diagnostic & Preventive:
- **Diagnostic:** Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:
  - Oral evaluations – two (2) times per calendar year.
  - Bitewing x-rays – two (2) times per calendar year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over.
  - Full mouth or panoramic x-rays – once (1) each five (5) years.

  **Preventive:** Provides for the following:
  - Prophylaxis (Cleanings) - two (2) times per calendar year.
  - Topical Fluoride – two (2) times per calendar year for dependent children under age nineteen (19).
  - Space Maintainers – for dependent children under age fourteen (14) and only for premature loss of primary molars.
  - Sealants – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

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

Major:
- **Special Restorative:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
- **Prosthodontics:**
  - a. Includes bridges, partial and complete dentures.
  - b. Repairs and adjustments of bridges and dentures.
  - c. Implants. Limited coverage with a valid predetermination of benefits required. If a valid predetermination of benefits is not submitted by the provider prior to the treatment, no payment will be allowed.
- **Temporomandibular Joint Dysfunction (TMI):** Includes specified non-surgical procedures (predetermination required).

Orthodontics:
Orthodontic appliances and treatment.
### Summary of Dental Plan Benefits
**WICHITA PUBLIC SCHOOLS (BUY UP PLAN)**
**Group #92704**
**Effective for January 1, 2017**

<table>
<thead>
<tr>
<th>Benefit % Paid</th>
<th>Delta Dental</th>
<th>Delta Dental Premier</th>
<th>Non-participating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSTIC &amp; PREVENTIVE</strong> (Not subject to Deductible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral evaluations – two (2) times per calendar year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bitewing x-rays – two (2) times per calendar year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full mouth or panoramic x-rays – once (1) each five (5) years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive: Provides for the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prophylaxis (Cleanings) - two (2) times per calendar year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Topical Fluoride – two (2) times per calendar year for dependent children under age nineteen (19).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space Maintainers – for dependent children under age fourteen (14) and only for premature loss of primary molars.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sealants – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BASIC</strong> (Subject to Deductible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ancillary: Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: Provides for extractions and other oral surgery including pre and post-operative care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular Restorative: Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Surgical periodontal procedures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR</strong> (Subject to Deductible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Restorative: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthodontics:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Includes bridges, partial and complete dentures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Repairs and adjustments of bridges and dentures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Implants. Limited coverage with a valid predetermination of benefits required. If a valid predetermination of benefits is not submitted by the provider prior to the treatment, no payment will be allowed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ORTHODONTICS</strong> (Subject to Deductible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics: Orthodontic appliances and treatment.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

$50 \times 3$

### Eligible Children Ages:
Dental Plan coverage is available for eligible dependents up to age twenty-six (26), regardless of whether they are full-time students, married, or have access to insurance through their own employer.

### Maximum Benefit(s) Per Person:
The Maximum Benefit for all Covered Services, including Temporomandibular Joint Dysfunction (TMJ), for each Enrollee in any one Calendar Year is: One Thousand Five Hundred Dollars ($1,500.00).

### Implant Services:
*The maximum payment for a valid, prior approved predetermination of Implant Services is Two Thousand Five Hundred Dollars ($2,500.00) per lifetime, per Enrollee. Implant coverage will not be included in the annual maximum benefit.
CHANGING YOUR BENEFITS DURING THE YEAR

IRS regulations limit when you can make changes to your benefits during the year. After you have made your elections during your first 30 days of eligibility, you cannot change your medical, dental, or FSA elections outside annual Open Enrollment (held each fall), unless you have a qualifying life event that permits you to make benefits changes under IRS rules.

If you have an eligible change, contact Benefits at (316)973-4522, as soon as possible because you only have 31 days from the event to make any changes.

Examples of qualifying life events that may allow you to make benefit changes:

- Marriage
- Divorce
- Birth
- Adoption
- Dependent Losing Eligibility — dependent child reaches the maximum age of 26
- Dependent Gaining Eligibility

DEPENDENT VERIFICATION REQUIREMENTS

- During Open Enrollment, you can add or drop dependents.
- Dependent eligibility verification documents are required for any new dependents added to the plan. You will be able to upload your documents during online enrollment.
- Social security numbers are required for all dependents.
- Individual Taxpayer Identification Numbers (ITIN) will also be accepted.

<table>
<thead>
<tr>
<th>Benefit Participant being added</th>
<th>Document(s) Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Copy of Marriage Certificate. Copy of Social Security Card</td>
</tr>
<tr>
<td>Dependent (0–26 yrs.)</td>
<td>Copy of Birth Certificate (with parental information). Copy of Social Security Card</td>
</tr>
<tr>
<td>Adopted Children</td>
<td>If the child is your adopted child and the birth certificate has not yet been amended to name you and other adoptive parent as the child’s parents, then the letter issued by the governmental agency placing the child in your home will suffice for documentation, until such reasonable time as the amended birth certificate can be issued. Copy of Social Security Card</td>
</tr>
<tr>
<td>Legal Dependents (Court Appointed)</td>
<td>You do not need to prove your relationship to the child’s parents if you are the child’s legal guardian. You must provide a copy of the guardianship appointment certified by the clerk of the court in which the appointment occurred. Copy of Social Security Card</td>
</tr>
</tbody>
</table>
ADDITIONAL BENEFIT OFFERINGS

As a benefitted employee, you also receive the following benefits paid for by the district:

* Employee Life Insurance
* Employee Assistance Program (New Directions)
* Workers Compensation Benefits
* Short Term Disability Benefits

You are also eligible to enroll or participate in the following voluntary programs:

**Voluntary supplemental life insurance**
Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself in this benefit, you pay the full cost through payroll deductions.

You will have the option to purchase supplemental life insurance during annual online open enrollment.

**457 (b) Deferred Compensation Plan**
457(b) deferred compensation plans are employer-sponsored retirement savings plans, offered by municipalities and governmental entities, which allow employees to defer a portion of their current compensation on a tax-advantaged basis for retirement.

With a 457(b) plan, employees put a portion of their earnings into an employer-sponsored plan on a tax-advantaged basis. Employees may choose between a traditional pre-tax contribution and a Roth contribution.

Traditional pre-tax contributions – Contributions are made on a pre-tax basis, reducing the employee’s taxable income. Earnings accumulate on a tax-deferred basis. All distributions are taxed as ordinary income.

Roth contributions – Contributions are made on an after-tax basis. Earnings accumulate on a tax-deferred basis, and distributions are tax-free if made five years after the initial contribution to the plan and the employee is over 59½.

For more information contact Deb Anton, your RPA Advisor:

<table>
<thead>
<tr>
<th>Deb Anton, MBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Advisor</td>
</tr>
<tr>
<td>316.210.5049</td>
</tr>
<tr>
<td><a href="mailto:danton@retirementplanadvisors.com">danton@retirementplanadvisors.com</a></td>
</tr>
</tbody>
</table>
BSWIFT ONLINE ENROLLMENT PORTAL

The plan-selection tool makes choosing your plan easy. Just answer a few simple questions, then view your plan options side by side to compare costs and coverage details.

LOGIN INFORMATION

When accessing the online enrollment site from self-service and/or a district computer, please use the following:

- **Username**: Network ID (usually first initial and last name)
- **Password**: Your network password.

Please contact the Help Desk at 973-HELP for password resets or login issues from work.

Note: If you are using a shared computer or a computer in a public place, like a library or community center, be sure you close all browser windows and tabs and log out when you are done. This will keep your information secure.

Beginning November 7, 2016, you can access the online enrollment site from home at www.usd259.bswift.com and using the following information to login:

- **Username**: Employee ID
- **Password**: The last four digits of your Social Security Number

You will be asked to change your temporary password after your initial login.

If you are still unable to log in, contact bswift at 1-866-524-5063. Representatives are available Monday through Friday from 8:00 a.m. to 6:00 p.m. CST.
Login to the benefit enrollment website
Click on the Start Your Enrollment button to begin enrolling in your benefits.

Enter your personal information
Make sure all your personal information, including your address and telephone number are correct.

Enter your family information
Enter your spouse’s information, along with your eligible dependent children, you would like to enroll in your benefits.
Wellness Verifications Made Easy

Your current wellness point status will be noted under your profile page and in the wellness tracker.

Upload Documents

Do you have pending wellness appointments scheduled before December 31, 2016?

Are you adding a new dependent & need to provide supporting documentation?

No problem. You can simply upload a copy of your supporting documents when you complete your online enrollment.
ONLINE ENROLLMENT TOOLS

Start selecting your benefits

From this screen you can select which benefits to enroll in or to waive (cash option). As you progress through each benefit type, you’ll see your selections.

View your plan options

Select who you’d like to cover with the plan at the top of the page, then view all of your plan options.

Ask Emma

By answering a few questions about your prescriptions and health care usage for the year, we can provide you with an out-of-pocket cost estimate for each plan offered.

Plan recommendations

Based on your answers, our avatar, Ask Emma, will recommend a plan for you based on the lowest out-of-pocket costs.
ONLINE ENROLLMENT TOOLS

Benefits jargon, explained
Ask Emma walks you through the meanings of complicated health benefit terms, with audio and video FAQs.

Choose your other benefits
You’ll select other benefits – like dental and vision – from this screen as you progress through each benefit type.

Review & confirm your selections
Take another moment to look over your selections and make any necessary changes.

You’re finished – view your confirmation statement
You can save or print your information, and you’ll have a record of your total costs. You can make changes until November 18, 2016.
# PLANNING WORKSHEET FOR ONLINE ENROLLMENT

**Employee ID #:** ________________

**Your Network Login Information:**

100 Wellness Points: □ Employee □ Spouse

Username: ________________ Password: ________________

## MEDICAL CHOICES:

<table>
<thead>
<tr>
<th></th>
<th>Employee Only</th>
<th>Employee + Child(ren)</th>
<th>Employee + Spouse</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Base Plan</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Medical Buy Up Plan—Option 1</td>
<td>$55.52</td>
<td>$105.47</td>
<td>$116.58</td>
<td>$172.10</td>
</tr>
<tr>
<td>Medical Buy Up Plan—Option 2</td>
<td>$38.71</td>
<td>$73.54</td>
<td>$81.27</td>
<td>$120.00</td>
</tr>
<tr>
<td>Cash Option - Waive Coverage</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

## DENTAL CHOICES:

<table>
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<tr>
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<th>Employee + Child(ren)</th>
<th>Employee + Spouse</th>
<th>Family</th>
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</thead>
<tbody>
<tr>
<td>Dental Base Plan</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Dental Premium Plan</td>
<td>$15.82</td>
<td>$30.05</td>
<td>$33.22</td>
<td>$49.04</td>
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</table>

<table>
<thead>
<tr>
<th>Dependent Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Provider (PCP) Full Name</th>
<th>Provider (PCP) ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(You)</td>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employee ID #:__________________

100 Wellness Points: Employee: □

Provider (PCP) ID Number: ________________
USEFUL TOOLS

Aetna Navigator® Member Website

When you’re an Aetna member, you get tools and resources to help you easily manage your health and your benefits. Your health benefits, health insurance plan information, and cost-savings tools are all located in one place — your Aetna Navigator member website. When you sign up and use it, you’re not just a member, you’re a navigator.

Just sign up at www.aetna.com once you are an Aetna member, you can start using Aetna Navigator’s valuable features and tools.

Once you’re a navigator, you can easily:
• Find the right doctor and save money. Locate in-network doctors who accept your plan.
• See what you owe. Look up claims to see how much the plan paid and what you may have to pay.
• Know your plan. Check who is covered by your plan and what it covers.
• Know estimated costs before you go. See cost estimates before you make an appointment for an office visit, test or procedure.

Aetna Mobile

The Aetna Mobile app puts our most popular online features at your fingertips. It’s available for iPhone® and Android™ mobile devices. Text Apps to 23862 to download. Or visit www.aetna.com/mobile.

Features of Aetna Mobile

You’re in your car, at the doctor’s office ... anywhere. You need that ID number or claims record now. With Aetna Mobile, you’ll get all the answers you need, instantly.

Find a doctor — it’s easy to search for doctors, dentists and specialists in your area.

Check benefits and coverage information — just clear, accurate details when you click.

Pull up your medical and/or dental ID card information — if you left your ID card at home, it’s no problem.

Member Payment Estimator — real-time estimates for out-of-pocket medical expenses based on your health plan.

Use the Urgent Care Finder — it’s for immediate help in an emergency. Because every minute counts.

Look up symptoms on the iTriage® app — it’s easy to search symptoms, conditions and medications.

Message Center — one location for all Aetna e-mail correspondence from Member Services.

Search claims — no more guesswork when you don’t have the paperwork with you.

View your disability or leave information — reference your existing claims, leaves and payments while you’re on the go.

More — for access to your personal health record.

Contact Us — for fast answers to your plan questions.
MaxorPlus’ new member portal

Brand new, easier to use MaxorPlus member portal and mobile app.

**So, what’s new?**

1. View/edit/manage dependents easier
2. Request new or replacement prescription card. Add/change credit card information
3. Print/view an enhanced Explanation of Benefits Pharmacy locator linked to Google Maps
4. New functionality for faster & easier online experience optimized for web, mobile and smartphone devices New, free to download App available on Android
5. Google Play or Apple iTunes store

**Q & A**

**Will members be required to register a new account for the new portal?**

Yes. The first time a member uses the portal, they will need to create a new account with their email address.

**Are members required to use the new portal?**

Yes; however, the current portal will be available for 120 days to allow members to register and make the transition to the new portal.

**Is the new member portal and App secure?**

Yes. Member data is encrypted and each login is authenticated for a secure user session.

**Who can members contact with questions or issues?**

Members can call toll-free at 1-800-687-0707, or email [contactus@maxor.com](mailto:contactus@maxor.com).
USEFUL TOOLS

Delta Dental Mobile App

Manage Your Benefits Anytime, Anywhere.
We make it easy for you to make the most of your dental benefits so you can maximize your health wherever you are. Delta Dental’s mobile app gives you access to dentist search, claims and coverage, ID cards and more - right on your mobile device.

DELTA DENTAL MOBILE APP
Delta Dental’s mobile app is available for smartphones and tablets using iOS (Apple) or Android. To download and install the app on your device, visit the Apple App Store or Google Play and search for Delta Dental.

Through Delta Dental’s mobile App you can:

♦ Find a Dentist - Search for dentists and specialists in your area that have the qualities that matter most to you.

♦ Check Coverage and Claims - Simply click My Coverage on the main menu to check your coverage information, see claims status, review your plan type and more.

♦ Use Your Mobile ID Card - Login to view your ID Card on the landing page, show it at the dental office or email it to a dependent or dentist.

♦ Toothbrush Timer - Use the toothbrush timer to make sure you (and your family!) keep up with your daily oral health routine.
USEFUL TOOLS

Free Mobile App!

Check out our easy-to-use mobile app!
What participants are saying:
“Fantastic Application!”  “This app is great for checking claims and filing claims.”
“Very easy to use and super convenient.”

Features

- Use your phone/tablet to file claims.
- Take a picture with your device’s camera to attach as documentation.
- View information regarding your account(s).
- Access your account statement.

Just scan the code with your mobile device to get the new app!

Visit WWW.ASI FLEX.COM for more information.
Customer Service
1-(800)-228-6481
www.aetna.com

The Wichita Public Schools dedicated customer service phone number will be located on the back of your Aetna ID card

Customer Service
1-(800)-234-3375
(316)-264-4511
www.deltadentalks.com

Pharmacy Benefit Questions
1-(800)-687-0707
http://www.maxor.com/maxorplus/members

Get Started Today
1-(800)-TELADOC
www.teladoc.com

For problems with the online enrollment system or problems logging in, contact bswift at 1-866-524-5063.

Representatives are available Monday through Friday from 8:00 a.m. to 6:00 p.m. CST.

Employee Assistance Program
1-(800)-624-5544
www.ndbh.com
Passcode: USD259
GLOSSARY

Health coverage pays for provided services, medications, hospital care, and special equipment when you’re sick. It is also important when you’re not sick. Here are explanations of some key health insurance words that you may hear.

**Affordable Care Act (ACA)**
The Patient Protection and Affordable Care Act (PPACA) - also known as the Affordable Care Act or ACA, is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010.

**Co-payment**
An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription drug. A co-payment is usually a set amount, rather than a percentage. For example, you might pay $30 for a doctor’s visit or $10 for a prescription.

**Co-insurance**
An amount you may be required to pay as your share of the cost for services after your deductible is satisfied. Co-insurance is usually a percentage (for example, 30%).

**Deductible**
The amount you owe for health care services before your health insurance or plan begins to pay.

**Explanation of Benefits (EOB)**
A summary of health care charges that your insurance company sends you after you see a provider or receive a service. It is not a bill. It is a record of the health care you or individuals covered on your policy received and how much your provider is charging your insurance company. If you have to pay more for your care, your provider will send you a separate bill.

**Formulary**
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

**In-network**
The facilities, providers, and suppliers your health plan has contracted with to provide health care services.

**Non-formulary**
Drugs that are not included in the list of preferred medications that a committee of pharmacists and doctors deems to be the safest, most effective and most economical. They are drugs not included in the drug list approved by Maxor Plus.
**Out-of-network**
A provider or facility who does not have a contract with your health plan to provide services to you. You will pay more to use them.

**Out-of-pocket Maximum**
The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. The out-of-pocket maximum includes the yearly deductible and may also include any co-insurance you have after the deductible.

**Out-of-network co-insurance**
The percent (for example, 50%) you pay of the allowed amount for covered health care services to providers who don’t contract with your health insurance or plan. Out-of-network co-insurance costs you more than in-network co-insurance.

**Preauthorization**
Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a guarantee of benefits.

**Primary Care Provider (PCP)**
The doctor you see first for most health problems. Your PCP makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your primary care doctor before you see any other health care provider. Your PCP must be a physician—Family Practitioner, Pediatrician, Internal Medicine, or General Practitioner.

**Specialist**
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

**Urgent Care**
Urgent care is non-preventive or non-routine health care service needed to prevent serious deterioration of a person’s health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in an Emergency Room. Often referred to as Immediate Care.
BENEFITS
OPEN
ENROLLMENT

November 7th — 18th