EMPLOYEE BENEFITS GUIDE

2022-2023 PLAN YEAR

BARTON
COMMUNITY COLLEGE

245 NE 30 RD • Great Bend, KS 67530

BENEFITS OVERVIEW

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

WELCOME TO THE 2022 BENEFITS OPEN ENROLLMENT

The Barton County Community College annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

TIP

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

REMEMBER

Outside of Open Enrollment, you may not make any changes to your plans without a Qualifying Life Event (QLE) which grants you a special enrollment period. If you experience a QLE, you only have 30 days to notify HR that you would like to make a change to your benefits.

Some common QLE's include

- You experience an involuntary loss of coverage
- Your employment or your spouse's employment terminates
- The hours you or your spouse work are reduced
- Birth, Adoption, Guardianship
- Marriage, divorce, annulment or legal separation
- Death of the employee, spouse or eligible dependent

MEDICAL BENEFITS

CARE OPTIONS AND WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting **https://benefitmanagementllc.com**/.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary / preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket.

TELEHEALTH/VIRTUAL VISITS

- Cold/flu
- Vomiting
- Fever
- Rash
- Sinus problems

Telehealth / Virtual Visits (powered by AmWell and/or Doctor on Demand) lets you see and talk to a doctor from your mobile device or computer without an appointment to bring you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS Caremark, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

MEDICAL BENEFITS

MEDICAL INSURANCE

Administered by Benefit Management

	In-Network PPO	Out-of-Network PPO
Annual Deductible (Individual/Family)	$700/$1,400	$700/$1,400
Annual Out-of-Pocket Maximum (Individual/Family)	$1,700/$3,400	$2,700/$5,400
Coinsurance	20%	40%
Benefits		
Office Visits	20% after ded	40% after ded
Emergency Room	20% after ded	20% after ded
Inpatient Services	20% after ded	40% after ded
Outpatient Services	20% after ded	40% after ded
Retail Pharmacy		
Retail— Generic Drug 34-day supply	$10 copay	$20 copay
Retail— Formulary Drug (Brand Tier I) 34-day supply	20% of allowed amount up to $60 copay	35% of allowed amount up to $120 copay
Retail— Formulary Drug (Brand Tier II) 34-day supply	20% of allowed amount up to $120 copay	35% of allowed amount up to $240 copay
Specialty Drugs 30-Day supply only	20% of allowed amount up to $300 copay/prescription	N/A
Mail Order— Formulary Drug (Brand Tier I) 90-day supply	20% up to $150 copay	35% up to $300 copay
Mail Order— Formulary Drug (Brand Tier II) 90-day supply	20% up to $300 copay	35% up to $600 copay

BALANCE BILLING

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $15,000 and the allowed amount for a Non-Network provider (120% of Medicare) is $500, the provider may bill you for the remaining $14,500. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Salina Regional Hospital is a Non-Network facility. If you decide to utilize Salina Regional Hospital or **any other Non-Network Facility for services**, other than an emergent situation, you will be subject to:

- Your out-of-network Deductible
- Your Co-Insurance
- The potential that you might receive a bill for the difference between the provider's charge and what our plans allows (balance billing). Depending on the procedure, Balance Billing from Non-Network Facilities can easily be thousands of additional dollars that the employee will be responsible for.

24/7 CALL-A-DOC
ACROSS THE NATION, AROUND THE CLOCK

MedWatch
Manage The Care, Monitor The Cost, Measure The Quality

Welcome to the future.

24/7 CALL-A-DOC is a premier telehealth provider of on-demand medical consultations over the phone, email, or online video. Once you take a few minutes to complete the registration process and add a brief medical history, you will have immediate access to top doctors, who are available to assist you with medical advice, non-emergency care and, if necessary, short-term prescriptions. Your medical records will be available to you at all times and be safely and securely protected in our medical record management system for your access only. Our goal is to help resolve you and your family's medical issues and concerns, wherever you are, at any time of day or night.

WHY 24/7 CALL-A-DOC?

Save Time – No more waiting on appointments or wasting time in waiting rooms.

Save Money – Avoid costly emergency room and urgent care co-pays.

Peace of Mind – A 24/7 Call-A-Doc physician is always just a call or click away.

Always There – Licensed doctors and nurses always available for you and your family.

BY THE NUMBERS

70% — **Up to 70%** of typical doctors' office visits can be handled by video or telephone

66% — **Up to 66%** of ER visits are not emergencies

$100s/ $1000s — **Save Money** on co-pays and deductibles

24/7 CALL-A-DOC is not an insurance provider. 24/7 CALL-A-DOC does not supersede your association with your primary physician. 24/7 CALL-A-DOC does not guarantee a prescription will be written. 24/7 CALL-A-DOC does not prescribe controlled substances or any other drugs with a high risk for abuse.

When to Use It

Many of your time-consuming and expensive visits to the doctor's office for common, minor conditions are unnecessary when you have 24/7 CALL-A-DOC. No more waiting in line at Urgent Care Clinics, or seeing a nurse or assistant when you want to talk to a doctor. Our physicians can help diagnose your condition, develop a treatment plan, and even send a prescription to your local pharmacy, quickly, easily, and conveniently!

For Example:

- ✔ Anytime you need to treat minor, common medical conditions quickly from the comfort of your own home
- ✔ If you have a general health-related question that you would like answered via our informational consultations
- ✔ Anytime you would like to save the time and expense of a trip to the doctor or clinic for non-emergency care
- ✔ When you are traveling or are away from a primary care physician
- ✔ When you'd like to skip the lines at urgent care or pharmacy clinics

- ✔ When you would like to talk to a doctor, instead of a nurse or assistant
- ✔ When a routine sinus infection, UTI or common condition reoccurs
- ✔ When the kids get an ear infection or other typical childhood ailment

COMMON CONDITIONS TREATED

Some of the conditions we can treat via phone or online video consultation:

- + Acid Reflux
- + Acne
- + Allergies
- + Asthma
- + Bronchitis
- + Cold & Flu Symptoms
- + Constipation
- + Diabetes
- + Ear Infection
- + Fever
- + Headaches/Migraines
- + Hemorrhoids
- + High Blood Pressure
- + Nausea
- + Pink Eye
- + Poison Ivy
- + Rashes
- + Respiratory Infection
- + Sinus & Nasal Conditions
- + Sore Throat
- + Stomach Virus
- + Urinary Tract Infection
- + Vomiting

TO SPEAK WITH A DOCTOR, ANYTIME DAY OR NIGHT CALL

844-DOC-24HR

OR VISIT WWW.247CALLADOC.COM

24/7 CALL-A-DOC is not an insurance provider. 24/7 CALL-A-DOC does not supersede your association with your primary physician. 24/7 CALL-A-DOC does not guarantee a prescription will be written. 24/7 CALL-A-DOC does not prescribe controlled substances or any other drugs with a high risk for abuse.

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DENTAL BENEFITS

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Administered by Benefit Management

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Barton Community College dental benefit plan.

	Dental Benefits
Annual Deductible (Individual/Family)	$50 / $100
Annual Benefit Maximum	$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100%
Basic Dental Services (fillings, extractions)	80%
Major Dental Services (crowns, inlays, onlays, bridges, dentures, repairs)	50%
Orthodontic Services Dependent children under age 19	Not Covered

VISION BENEFITS

VISION BENEFITS

Administered by Vision Care Direct

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

	VCD Standard Network	VCD PLUS Network	Out-of-Network
Eye Exam — once every 12 months	Included in medical plans		
Member Fees			
Eye Exam	N/A	N/A	N/A
Glasses	$15	$15	$0
Polycarbonate for Kids	$25	$25	$0
Contacts	$0	$0	$0
Lasik	$0	$0	$0
Lenses — once every 12 months			
Polycarbonate lenses for children (once every 12 months)	100%	100%	$0
Single Vision Lenses	100%	100%	Up to $50
Lined Bifocal Lenses	100%	100%	Up to $75
Lined Trifocal Lenses	100%	100%	Up to $100
Lens Options			
Scratch Resistant Coating	Not included	100%	$0
Ultraviolet Coating	Not included	100%	$0
Anti-Reflective Coating	Not included	100%	$0
Oil & Water Resistant Coating	Not included	100%	$0
Polycarbonate for Kids (after PK fee listed above)	100%	100%	$0
Polycarbonate for Adults	Not included	Not included	$0
Frames — once every 12 months			
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	Elective: $130 Medically Necessary: $750	Elective: $130 Medically Necessary: $750	Elective: $80 Medically Necessary: $80

ADDITIONAL BENEFITS

HARTFORD LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

- $20,000 policy that is paid for by the college
- Voluntary policy based on employee class. Cost is shared between the college and the employee

HARTFORD SHORT TERM DISABILITY

- Employee paid Short Term Disability is available to full-time employees

KPERS

- The college provides retirement through the Kansas Public Employees Retirement System. It is mandatory that all full-time employees participate. Employees contribute 6% of their salary, which is deducted from their paycheck each month.
- KPERS Basic Group Life Insurance and Long-Term Disability Insurance is included with membership.
- KPERS Optional Life Insurance – Additional Life Insurance is available to members to qualify.

AFLAC

- Employee paid Cancer, Critical Illness and Accident Insurance are available to full-time employees

403(B)

- The college offers optional participation in this retirement plan.

CONTACT INFORMATION

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Benefit Management, Vision Care Direct of Kansas, UMB Bank, or your Barton County Community College Benefits Representative.

Contact Information			
Benefit Management	Medical and Dental Insurance	**888.922.4622**	https://benefitmanagementllc.com/
Vision Care Direct of Kansas	Vision Insurance	**877.488.8900**	https://visioncaredirect.com/
Hartford	Kaci Wells	**620.793.9190**	kaci@cpcis.net
Aflac	Kaci Wells	**620.793.9190**	kaci@cpcis.net
403(b)	Leslie Klug	**620.792.7577**	leslie@francisfinancial.us
BCC Benefits Specialist	Rebecca Herrman	**620.792.9222**	herrmanr@bartonccc.edu

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

Benefit Plan	Monthly
MEDICAL	
Employee Only (non-tobacco)	$0
Employee Only (tobacco user)	$50
Employee & Child (non-tobacco)	$204
Employee & Child (tobacco user)	$254
Employee & Spouse (non-tobacco)	$275
Employee & Spouse (tobacco user)	$325
Employee & Family (non-tobacco)	$427
Employee & Family (tobacco user)	$477
DENTAL	
Employee Only	$3
Employee & Child	$5
Employee & Spouse	$5
Employee & Family	$8
VISION	
Employee Only	$7.73
Employee & Child	$14.27
Employee & Spouse	$12.36
Employee & Family	$24.26

IMPORTANT NOTICES

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

IMPORTANT NOTICE FROM BARTON COUNTY COMMUNITY COLLEGE 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 United Healthcare 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. Barton County Community College has determined that the prescription drug coverage offered by the United Healthcare health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Barton County Community College coverage may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Barton County Community College medical plan, be aware that you and your dependents may not be able to get this coverage back.

This notice is a summary. For a full description of all of Barton County Community College' Benefit plans, please refer to the Summary Plan Descriptions, located at: Human Resources.

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 Barton County Community College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium

may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Barton County Community College changes. You also may request a copy of this notice at any time.

Contact: Rebecca Herrman | **herrmanr@bartonccc.edu** | **620.792.9222**

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.**
- 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**, or call them at **1.800.772.1213** (TTY **1.800.325.0778**).

Date:	July 23, 2022
Name of Entity/Sender:	Barton County Community College
Contact:	Rebecca Herrman, Human Resources Benefits Specialist
Address:	245 NE 30 Rd, Great Bend, KS 67530
Phone Number:	620.792.9222
Fax Number:	620.786.1168
Email	herrmanr@bartonccc.edu

IMPORTANT NOTICES

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 **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 **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health- insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739

IMPORTANT NOTICES

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

IMPORTANT NOTICES

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

Barton County Community College has amended the Medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2022. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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)? Contact Rebecca Herrman at **620.792.9222** for more information.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Rebecca Herrman at **620.792.9222.**

IMPORTANT NOTICES

INITIAL COBRA NOTICE

INTRODUCTION

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

IMPORTANT NOTICES

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Rebecca Herrman at **620.792.9222**

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

IF YOU HAVE QUESTIONS -

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES -

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

PLAN CONTACT INFORMATION -

Rebecca Herrman
herrmanr@bartonccc.edu
620.792.9222

Barton Community College Organized Health Care Arrangement ("OHCA")

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the legal obligations of Barton County Community College Organized Health Care Arrangement (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Notice describes the circumstances under which your protected health information may be used or disclosed by the Plan to carry out treatment, payment or health care operations or for any other purpose that is permitted or required by law.

In general, "protected health information" is individually identifiable information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, including the Plan, or by Barton County Community College on behalf of the Plan, that relates to the following:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) your past, present or future payment for the provision of health care to you.

I. The Plan's Responsibilities Regarding Protected Health Information

Barton County Community College Employee Health Care Plan and Barton County Community College Flexible Benefit Plan have, for purposes of complying with the HIPAA medical privacy regulations, formed an organized health care arrangement that is referred to in this Notice as the Plan. An organized health care arrangement ("OHCA") is authorized to issue a joint Notice of Privacy Practices and develop one set of policies and procedures applicable to all group health plans that are members of the OHCA. Group health plans that are members of an OHCA are authorized to share protected health information with each other as necessary to carry out treatment, payment or health care operations and as necessary to manage and operate the organized health care arrangement. Each group health plan that is a member of the Plan is considered "self-funded." The Plan, on behalf of its individual members, is required by law to:

- protect and maintain the privacy of your protected health information in accordance with HIPAA;
- provide you with certain rights relating to your protected health information;
- prepare and maintain this Notice of our legal duties and privacy practices with respect to your protected health information;
- provide a copy of this Notice to you;
- provide a copy of this Notice to an individual at the time he or she enters a group health plan that is a member of the Plan;
- within 60 days of a material modification of this Notice, provide a copy of the revised Notice to you;
- no less frequently than every three years, notify all individuals enrolled in a group health plan that is a member of the Plan of the availability of this Notice and how to obtain a copy; and
- follow the terms of the Notice that is currently in effect.

II. How the Plan May Use and/or Disclose Your Protected Health Information

The following categories describe different ways that the Plan may use and/or disclose your protected health information. For each category, use or disclosure, this Notice will explain what is meant and will present some examples. Not every use or disclosure in a category will be listed. However, all the ways the Plan is permitted to use and disclose your protected health information will fall within one of the categories.

For Treatment. The Plan may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, the Plan may disclose your protected health information to your health care provider for purposes of coordinating your health care with the Plan or referring you to another provider for care.

For Payment. The Plan may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service provider. Likewise, the Plan may share protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

In addition, an explanation of benefits ("EOB"), which may contain information such as the name of the individual receiving treatment, the name of the health care provider, the date medical care is received, the amount charged for medical care, and the amount paid for medical care, may be sent to the individual through whom coverage is provided. For example, a covered employee may receive an EOB disclosing the information listed above with respect to his or her spouse or any dependents covered through such employee. This disclosure for payment purposes is subject to an individual's right to request confidential communications as explained in Section V below.

For Health Care Operations. The Plan may use and disclose your protected health information for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use protected health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

To a Business Associate. The Plan may enter into contracts with individuals or entities known as Business Associates to perform various functions on behalf of the Plan or to provide certain types of

services to the Plan. To the extent necessary to perform these functions or to provide these services, Business Associates may receive from the Plan, create from information provided from the Plan, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plan to implement and follow appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate agrees in writing to protect your protected health information to the same extent as the Plan.

To the Plan Sponsor. The Plan may disclose your protected health information to certain employees of Barton County Community College for purposes of administering the Plan. However, those employees will only use or disclose the information received only as necessary to perform Plan administrative functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information may not be used for employment purposes without your specific authorization.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may disclose protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Organ and Tissue Donation. If you are an organ donor, the Plan may disclose protected health information about you to organizations that handle organ donor procurement or transplantation, as necessary to facilitate organ or tissue donation and transplantation.

Public Health Risks. The Plan may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- to notify the appropriate government authority if we believe a participant has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also disclose protected health information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may disclose your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your protected health information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. The Plan may disclose your protected health information to researchers when (1) all individual identifying information has been removed; or (2) when an institutional review board or privacy board (a) has reviewed and approved the research proposal, and (b) has established protocols to ensure the privacy of the requested information.

III. Circumstances under Which the Plan Must Disclose Your Protected Health Information

The Plan is required by law to make disclosures of your protected health information in the following circumstances:

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; or
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

In Connection with Government Audits. The Plan is required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA.

Disclosures to You. When you request, the Plan is required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your protected health information, where the disclosure was for reasons other than for payment, treatment or health care operations, and where the disclosure was not pursuant to your written authorization.

IV. Other Uses of Protected Health Information

Uses and disclosures of your protected health information not otherwise described in this Notice or the laws that apply to the Plan will be made only with your written permission. If you give the Plan permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose your protected health information for the reasons covered by your written authorization. However, this will not affect any disclosures that have already been made with your permission.

V. Your Rights Regarding Your Protected Health Information

You have the following rights regarding medical information maintained by the Plan about you:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Contact Person (see section VIII below). The Plan has prepared and will provide to you upon request a "Request For Access to Protected Health Information" form that may be used by you for this purpose. To request a copy of this form, please contact the Contact Person. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

In very limited circumstances, the Plan may deny your request to inspect and copy protected health information that may be used to make decisions about your Plan benefits. If you are denied access to your protected health information that may be used to make decisions about your Plan benefits, you may request that the denial be reviewed by submitting a written request to the Contact Person (see section IX below).

Right to Amend. If you feel that protected health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Contact Person (see section VIII below). The Plan has prepared and will provide to you upon request a "Request to Amend Protected Health Information" form that may be used by you for this purpose. To request a copy of this form, please contact the Contact Person. You must provide a reason that supports your request. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations, unless it involves a disclosure of an electronic record of health-related information on an individual that is created, gathered, managed and consulted by

authorized healthcare clinicians and staff; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Contact Person (see section VIII below). The Plan has prepared and will provide to you upon request a "Request for Accounting of Disclosures of Protected Health Information" form that may be used by you for this purpose. To request a copy of this form, please contact the Contact Person. Your request must state a time period, which may not be longer than six years (or three years in the case of disclosures involving electronic health records, as described above) and may not include dates before April 14, 2004 if the Plan was in effect on that date or, if later, the date the Plan was established. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the cost of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on your protected health information disclosed by the Plan to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan is not required to agree to your request. However, if your request relates to restricting the disclosure to another health plan of your protected health information pertaining solely to a health care item or service for which the health care provider has been paid out-of-pocket in full and where the purpose of the disclosure would have been for carrying out payment or health care operations, the Plan must agree to your request.

To request restrictions, you must make your request in writing to the Contact Person (see section VIII below). The Plan has prepared and will provide to you upon request a "Request for Restrictions to Protected Health Information" form that may be used by you for this purpose. To request a copy of this form, please contact the Contact Person. In your request you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Contact Person (see section VIII below). The Plan has prepared and will provide to you upon request a "Request for Confidential Communications" form that may be used by you for this purpose. To request a copy of this form, please contact the Contact Person. Generally, the Plan is not obligated to grant your request for confidential communications unless you provide information establishing that disclosure of all or part of your protected health information in a manner or at a location other than that requested could endanger you and the request is reasonable. Your request must specify how or where you wish to be contacted.

Right to Request Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, please contact the Contact Person (see section VIII below).

VI. Effective Date

This Notice is effective November 1, 2022.

VII. Changes to this Notice

The Plan reserves the right to change this Notice. The Plan reserves the right to make the revised or changed notice effective for protected health information that the Plan already has about you as well as any information the Plan creates or receives in the future.

VIII. Questions About this Notice

If you have any questions about this Notice or would like to receive a copy of this Notice or any of the forms referenced in this Notice, please contact the Plan's Contact Person. The Plan's Contact Person is Julie Knoblich, Director of Human Resources who may be contacted at 245 NE 30 Road, Great Bend, KS 67530; or by telephone (620) 792-9275.

IX. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the United States Department of Health and Human Services, Office of Civil Rights. To file a complaint with the Plan, contact Julie Knoblich, Director of Human Resources, 245 NE 30 Road, Great Bend, KS 67530. All complaints must be submitted in writing. To file a complaint with the Office of Civil Rights, contact the United States Department of Health and Human Services, Office of Civil Rights, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You will not be penalized or retaliated against for filing a complaint.

IMPORTANT NOTICES

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- are past, or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service; then an employer may not deny you:
- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment
- because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

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

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1.866.4-USA.DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/ elaws/ userra.htm**.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the
- Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

NOTES

NOTES

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

This is a brief description of your benefits. If a discrepancy exists, benefits outlined in the carrier certificate will prevail.