LEGAL NOTICES

NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise or balance billing. Additionally, you are never required to give up your protections from balance billing and not required to get care out-of-network. You are only responsible for paying your share of the cost that you would pay if the provider or facility was in-network.

CONTINUATION OF HEALTH PLAN COVERAGE

A federal law, commonly referred to as COBRA (for Consolidated Omnibus Budget Reconciliation Act) gives you and your covered dependents the right to continue health plan coverage in certain circumstances when it would otherwise end. These include termination of employment or reduction in hours causing loss of plan eligibility of the covered employee, as well as for covered dependents, the death of the covered employee, a divorce or legal separation from the covered employee, or ceasing to be an eligible dependent child of the employee.

IT IS VERY IMPORTANT THAT YOU NOTIFY THE EMPLOYEE BENEFITS OFFICE IF YOU EXPERIENCE A DIVORCE/LEGAL SEPARATION OR HAVE A DEPENDENT WHO NO LONGER MEETS THE ELIGIBILITY RULES OF THE PLAN.

If you do not notify the Employee Benefits Office of one of these events within 60 days, your covered dependents will lose the right to continue their coverage under COBRA. More details are available in the COBRA notification material sent to new health plan participants.

NOTICE OF SPECIAL ENROLLMENT PROVISIONS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after you or your dependents lose eligibility for that other coverage (or employer contributions toward that coverage end). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment, contact the Employee Benefits Office.

HIPAA PRIVACY

The USD 261 Medical Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by The USD 261 Medical Plan is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through the Employee Benefits Office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all stages of the mastectomy, including lymphedemas.

These benefits will be provided, subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

SPECIAL RULES FOR MOTHERS AND NEWBORNS

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or (96 hours).

LEGAL NOTICES

NOTICE OF CHIPRA POLICY

(Medicaid and the Children's Health Insurance Program (CHIP); Offer Free or Low-Cost Health Coverage to Children and Families)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS - NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

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

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

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law took effect in 2014, it established a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

Is My Current Health Insurance Coverage Changing Through My Employer?

NO. The Health Insurance Marketplace is another option for obtaining health insurance coverage.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage.

Also this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than **9.61** percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Employee Benefits Office.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Employer Name:	Haysville USD 261
Employer EIN:	48-0697340
Employer Address:	1745 W Grand | Haysville, KS 67060
Employer Phone:	(316) 554-2200

Who Can We Contact About Employee Health Coverage at This Job?

Employee Benefits Office

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

- We offer a health plan to all employees working 30+ hours per week
- We offer coverage to eligible spouses and dependent children to age 26

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

LEGAL NOTICES

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with USD 261 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. BCBSKS has determined that the prescription drug coverage offered by USD 261 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is 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 15 to December 7. However, if you decide to drop your current creditable coverage with USD 261 since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current USD 261 coverage will not be affected. You may keep your USD 261 coverage and this plan may coordinate with Part D coverage. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be able to keep these important benefits if you choose to enroll in a Medicare prescription drug plan. If you do decide to join a Medicare drug plan and drop your current USD 261 coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with USD 261 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 prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact Human Resources at **(316) 554-2200**. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through USD 261 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

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

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

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