EMPLOYEE BENEFITS GUIDE

2023-2024 PLAN YEAR

BARTON
COMMUNITY COLLEGE

245 NE 30 RD • Great Bend, KS 67530

BENEFITS OVERVIEW

TABLE OF CONTENTS

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 2023 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 **www.valuehealth.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 Value Health Benefit Administrators

	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 Coinsurance
- 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.

Member Support: Anytime, Anywhere.

Access Elixir online and use our mobile app to manage your pharmacy benefits on the go.

Access your pharmacy benefits online:

1. Visit **elixirsolutions.com** and select **REGISTER or LOGIN**
2. Have your Member ID card handy and follow the registration instructions
3. Bookmark the login page

Stay Connected with our App

- Search 'Elixir Rx Solutions' in your device's app store
- Once the app is downloaded, select REGISTER if you are a first-time user, or log in with your user name and password.

Log in now to use these features and more:

- Receive personalized savings alerts
- Compare drug pricing and view recent prescription information
- View and print your Member ID card or save it to your mobile wallet*
- Contact an expert online or in the app to get your medication questions answered quickly
- Search to find network pharmacies and filter by open 24 hours, drive-thru pickup and much more
- Manage your mail order account—easily transfer eligible prescriptions, order and refill medications, track shipping and more

Applicable only when using the mobile app.

As your pharmacy benefit manager, Elixir is here to help!
Visit elixirsolutions.com.

elixir
CRAFTED Rx SOLUTIONS

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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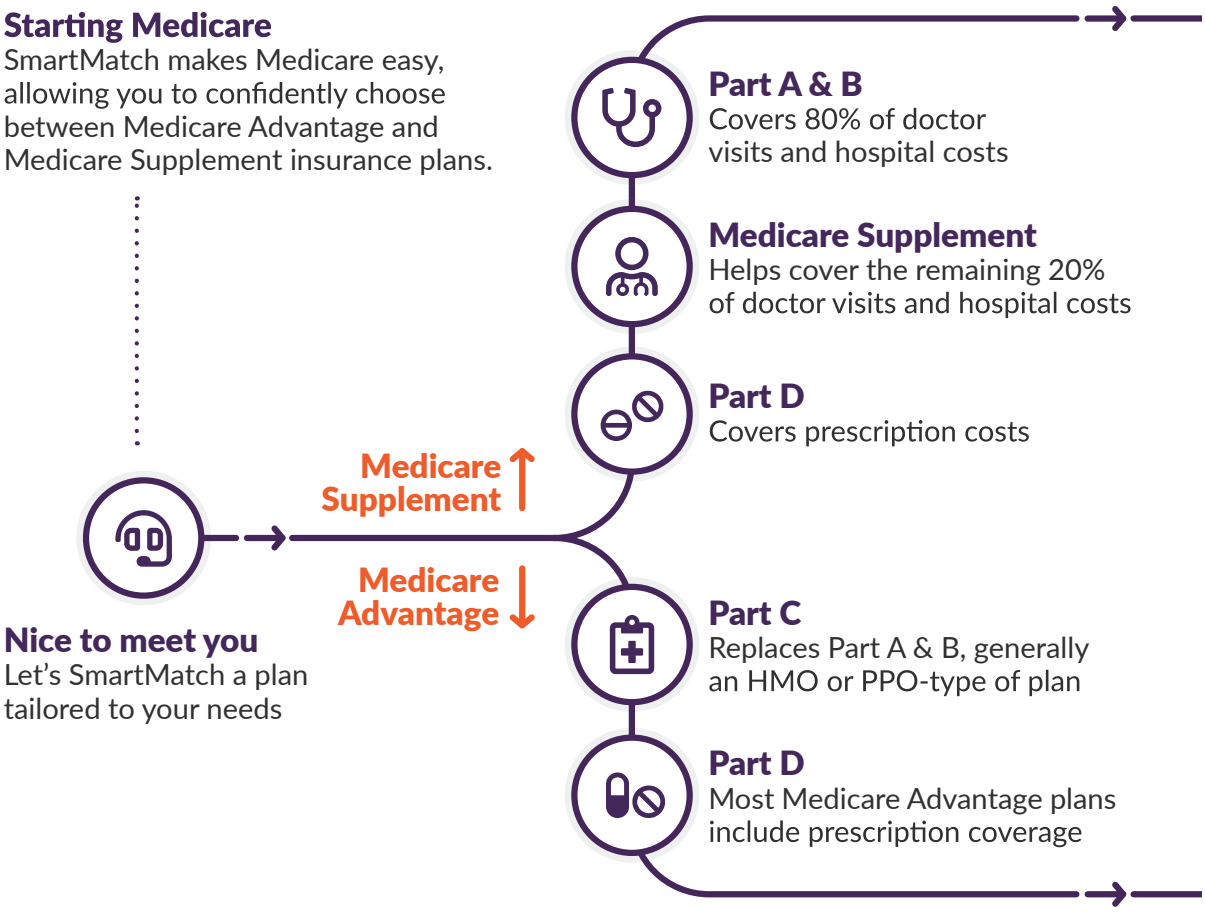
SmartConnect POWERED BY SMARTMATCH

ParetoHealth

(855) 248-1648 | TTY: 711
Mon - Fri, 7:30 a.m. - 5 p.m. CT

The Medicare Roadmap

Medicare can pull you in different directions. Our licensed insurance agents provide the full range of options available, along with strategies and information to help you see the complete picture.



SmartMatch Insurance Agency, LLC • Learn more: **connect.smartmatch.com/pareto** • 3/5

PARETO CancerCARE+
Integrated Population Management

Pareto CancerCARE+ Difference

- All patients covered on the health plan have access to our program at no cost to them.
- The CancerCARE solution starts with confirmation of the diagnosis and staging then utilizes clinical pathways prior to treatment planning.
- 90% of care can be provided in the local community.
- Financial estimates of the drug regimens are included.
- Benefit Plan Language & Employee Engagement Materials are provided.

Cancer Claims are Expensive, Complex and Rising Faster than Overall Healthcare Costs

- **Up to 25% of cancers are misdiagnosed or misstaged**
- **Expensive care does not always equate to the best outcome**
- **Most utilization management occurs after the treatment plan is set**
- **Patients want to avoid unnecessary, harmful & expensive treatments**

CancerCARE utilizes early engagement, national resources and clinical experts to **guide your patients through** their cancer treatment. We coordinate with oncologists **to help** select the **most appropriate clinical pathway** while also identifying the **most cost-effective facilities and drugs** covered by your plan.

Our services include:

- A proprietary "Triage Matrix" that immediately identifies patient risk
- A second opinion program for misdiagnosed or misstaged cancers
- A NCCN® Licensing Agreement that allows the Plan to tie benefits to NCCN Guideline® adherence
- Licensed software identifies most effective therapies at the lowest cost
- Medical Concordance review using nationally accepted guidelines ensures evidence-based care.
- A team of oncology experts that works to improve care & reduce costs
- Access to Cancer Centers of Excellence for complex treatment needs

Patients benefit from well-defined benefit plan language, significant cost savings and peace of mind.

4660 NE Belknap Court, Suite 209, Hillsboro, OR 97124 Tel 800.599.9119 Fax 503.640.6277 WWW.INTERLINKHEALTH.COM

FLEXIBLE SPENDING ACCOUNTS (FSA)

FLEXIBLE SPENDING ACCOUNTS (FSA)

Administered by Value Health Benefit Administrators

Barton County Community College is offering you the opportunity to participate in the Healthcare and/or Dependent Care Flexible Spending Account(s) (FSAs), which can save you valuable tax dollars by lowering your taxable income.

You decide how much to set aside based on your estimate of the amount you and your family will spend for eligible healthcare and dependent day care expenses during the plan year. The amount you elect to set aside is divided by the number of paychecks you receive during the plan year.

If you want to participate in both a Healthcare FSA and a Dependent Care FSA, you must enroll in each account separately. You cannot use money from a Healthcare FSA to pay for dependent day care expenses, or vice versa.

You must actively re-enroll each year to participate in a Flexible Spending Account by making an annual contribution election during Open Enrollment, or when first eligible. Once you elect a contribution amount you cannot change that amount during the plan year, unless you experience a qualifying change of status life event.

Remember to estimate your expenses conservatively when electing your annual FSA contribution. You must incur eligible expenses during the plan year, November 1st, 2023 to October 31st, 2024. You have until January 30th to submit eligible reimbursement requests that were incurred during the benefit period. Up to $500 can be rolled over to the next benefit period. Any funds left at the end of the benefit period in excess of $500 will be forfeited.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

The Healthcare Flexible Spending Account allows you to pay for a wide range of eligible health, dental and vision-related expenses not fully reimbursed under your plan. The expenses can be paid with pretax dollars. **An individual can contribute up to $3,050 to a Healthcare FSA.** The following are examples of expenses that you could be reimbursed for:

- Medical or dental copayments, deductibles and coinsurance
- Prescription drug copayments
- Orthodontia
- Contacts, glasses and laser eye surgery

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account allows you to pay for eligible dependent care expenses with pretax dollars. The annual maximum that you may contribute to the Dependent Care Flexible Spending Account is $5,000 if your end of year tax filing status is married, filing jointly, or single head of household. However, that maximum is reduced to $2,500 if you are married and filing separate tax returns. Eligible expenses include:

- Child care and adult care
- Daycare and after-school care

For a detailed listing of eligible and ineligible expenses, refer to IRS Publication 503 which is available from the IRS website at **www.irs.gov/pub/irs-pdf/p503.pdf.**

CAN I ENROLL IN AN HSA & FSA?

Under IRS rules, an employee who is covered by any health plan that is not a qualified High Deductible Health Plan (HDHP) is generally not eligible to establish or contribute to a Health Savings Account (HSA). General purpose health FSAs – FSAs that reimburse most deductible healthcare expenses – are not qualified HDHP plans, and enrollment in a general purpose health FSA makes an individual HSA ineligible. Because our general purpose health FSA has a carryover provision, enrollment in our general purpose FSA makes you HSA-ineligible for both the year in which you enroll in the general purpose FSA **and the following year**. However, we do have a Limited Purpose FSA which is available if employees are enrolled in the HDHP plan and contributing to the HSA. The Limited FSA is to be used for dental and vision only.

In order to prevent a loss of HSA eligibility during the upcoming plan year, if you are enrolled in our general purpose health FSA this year and elect to be covered under our HDHP next year and want to establish or contribute to an HSA, you will need to waive your carryover right before the end of the year in order to be HSA eligible next year. **If you do not waive your carryover right before November 1st, 2023 you will be HSA ineligible for all of next year.**

To learn more please visit **www.valuehealth.com**.

DENTAL BENEFITS

DENTAL BENEFITS

Administered by Value Health Benefit Administrators

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			
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 Value Health Benefit Administrators, Vision Care Direct of Kansas, UMB Bank, or your Barton County Community College Benefits Representative.

Contact Information			
Value Health Benefit Administrators	Medical and Dental Insurance	**888.922.4622**	www.valuehealth.com
Value Health Benefit Administrators	Flexible Spending Account	**888.887.2619**	www.valuehealth.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
BCCC 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, 2023
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, 2023. 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 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPPPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
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.mymaineconnection.gov/benefits/s/?language=en_US 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: 711 | Email: masspremassistance@accenture.com
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://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)

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
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs 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, 2023, 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 1/31/2026)

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 2023. 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

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

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.

DCN23BGBCCC