ELIZABETH LAYTON CENTER

For Hope and Guidance

2018 Benefits Overview

Medical, Dental, Vision, Life/AD&D, Voluntary Life/AD&D, Short/Long Term Disability, Critical Illness and Accident
Effective 01/01/2018 – 12/31/2018

Employee Benefits Plan

We recognize that our employees are our most valuable resource and your benefits plan is extremely important to Elizabeth Layton Center. Therefore, it is our pleasure to offer our benefits-eligible employees a variety of solutions to help address your benefit needs, as well as the needs of your families.

Our employees continue to be the driving force behind our past success and position us well for the future. Thank you for your ongoing commitment as we strive to be the best employer in our industry. We are proud to include all of you as part of the Elizabeth Layton Center family.

This summary of benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage.

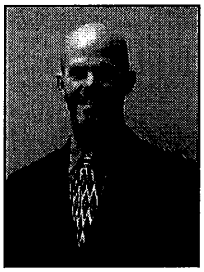
Bukaty Companies Service Team

Primary Service Contact
Chris Stitt
Client Service Manager
cstitt@bukaty.com
913.647.5547

Chris is responsible for the day-to-day administrative and service issues including claims, billing, ID card requests, enrollment issues and employee terminations.

Michael Looney
Benefits Consultant
mlooney@bukaty.com

Michael oversees all aspects of your employee benefits program.



Patrick Looney
Executive Vice President & Principal
plooney@bukaty.com

Patrick oversees all aspects of your employee benefits program.

Millie Kingsbury
New Business and Renewal Specialist
mkingsbury@bukaty.com
(913) 222-5563

Millie works with carriers to obtain competitive health insurance quotes for both prospects and clients, prepares comparison spreadsheets, assists in the group renewal process, as well as with the enrollment and underwriting stages.

Bukaty Companies
4601 College Boulevard Suite 100
Leawood, KS 66211
Phone: 913.345.0440
Fax: 913.345.2608
www.bukaty.com

25 YEARS BUKATY COMPANIES

Rights & Disclosures

This information is intended to be shared by employees with their spouse and dependents.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or to obtain more information contact Bukaty Companies at 888.657.0440.

Woman's Health and Cancer Rights Act (WHCRA) of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Bukaty Companies at 888.657.0440 for more information.

COBRA Rights In the Event You Lose Your Health (Medical/Dental/Flex) Coverage…

A group health plan is required to offer COBRA continuation coverage to you, your spouse and your dependents enrolled in the Plan when a qualifying event occurs that causes loss of group health coverage. Coverage may be available for 18 months up to a maximum of 36 months, depending upon the qualifying event. The employer is required to notify the Plan if the qualifying event is:

- Termination (for any reason other than gross misconduct) or reduction in hours of employment of the covered employee - eligible for up to 18 months of continuation coverage
- Death of the covered employee - eligible for up to 36 months of continuation coverage
- Covered employee becomes entitled to Medicare - eligible for up to 36 months of continuation coverage depending upon date of Medicare entitlement

The covered employee or one of the qualified beneficiaries is responsible for notifying the Plan Administrator within 60 days of the occurrence if the qualifying event is:

- Divorce or legal separation - eligible for up to 36 months of continuation coverage
- A child's loss of dependent status under the Plan - eligible for up to 36 months of continuation coverage.

Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of coverage for a total 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 continuation coverage. To obtain the extended coverage, a copy of the SSA disability determination must be received by the Plan Administrator within 60 days after the determination is issued and within the individual's first 18 months of continuation coverage. If SSA determines later the individual is no longer disabled, that individual must notify the Plan Administrator within 30 days after the date of the second determination.

Second Qualifying Event

If while on 18 months of continuation coverage, family members enrolled in the Plan experience another qualifying event, they may be entitled to an additional 18 months of coverage, for a maximum of 36 months. The extension may be granted if the employee or former employee dies, becomes entitled to Medicare or gets divorced or legally separated, or if the dependent child loses dependent status, but only if the events would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. When responsibility for notification rests with the covered employee or qualified beneficiary, notice of the qualifying event must be made within 60 days of the occurrence to the company's Plan Administrator.

Other Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to company's Plan Administrator. 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.

25 YEARS BUKATY COMPANIES

Keep Us Informed of Status Changes
It is very important that you keep your Plan Administrator informed of address changes and other personal data changes for you and/or dependents who are or may become qualified beneficiaries on any of the company's group benefits. Changes should be reported to the Plan Administrator.

A detailed explanation of COBRA rights and procedures is available in the Plan's Summary Plan Description.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

KANSAS – Medicaid	**MISSOURI** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Lifetime limit
The lifetime limit on the dollar value of benefits under your group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Bukaty Companies at 888.657.0440.

Important Notice from Special Neighbors 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 Elizabeth Layton Center 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:
*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.
Elziabeth Layton Center has determined that the prescription drug coverage for plans 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.
For more information about Medicare prescription drug coverage:
Visit www.medicare.gov or Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

BlueCross BlueShield of Kansas

Medical: BCBS of KS

You are eligible to participate in the medical benefit plan on the first of the month following date of hire. Eligible dependents may also participate; eligible dependents include dependent child(ren) to age 26 and under. Spousal coverage only available with completed affidavit form.

For questions concerning your medical benefits, a claim, to identify a network provider, or questions concerning your prescription drug coverage please contact BCBS of Kansas at 1-800-432-3990 or visit our website at www.bcbsks.com.

Option 1 - $500 Deductible - Rate Breakdown:

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$552.87	$1,187.46	$1,143.18	$1,777.78
Employer Pays	$298.55	$641.23	$617.32	$960.00
Employee Pays	$254.32	$546.23	$525.86	$817.78

Blue Cross Blue Shield of Kansas **Comprehensive Major Medical** Grp: Ins: **Coverage Period: Beginning on or after 1/1/2018**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsks.com/blueaccess or call 1-800-432-3990. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsks.com/blueaccess or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person/**$1,000** family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Coinsurance is 20% to a max of **$2,500** person / **$5,000** family. Total out of pocket max is **$5,000** person / **$10,000** family. 20% non PPO penalty applies annually up to **$2,000** person / **$4,000** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsks.com /providerdirectory** or call 1-800-432-3990 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 6, 2016

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	$35 copay/visit	——none——
	Specialist visit	$35 copay/visit	$35 copay/visit	——none——
	Preventive care/screening/immunization	$0. Preventive is without cost share.	Deductible then 20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsks.com	Generic drugs	$15 copay	$15 copay	——none——
	Preferred brand drugs	$30 copay	$30 copay	——none——
	Non-preferred brand drugs	$45 copay	$45 copay	——none——
	Specialty drugs	Copay as applicable on the above three categories	Not Covered	Specialty Drugs must be obtained from the Blue Cross and Blue Shield of Kansas Designated Specialty Pharmacy. If a Specialty Prescription Drug is obtained from a pharmacy other than our Designated Specialty Pharmacy, the drug will not be eligible for benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
If you need immediate medical attention	Emergency room care	$100 copay then deductible and 20% coinsurance	$100 copay then deductible and 20% coinsurance	——none——
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Urgent care	$35 copay/visit	$35 copay/visit	Same as office visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	none
	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Habilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Skilled nursing care	Not Covered	Not Covered	none
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Hospice services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	$35 copay/visit	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adult)	• Hearing aids	• Long-term care
• Weight loss programs		

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility treatment	• Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html	• Private-duty nursing
• Routine eye care (Adult)	• Routine foot care	• Spinal manipulations

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess, or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese		1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood work)	
Specialist visit (anesthesia)	
Total Example Cost	**$12840**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$130
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3170**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Primary care physician office visits (including disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glucose meter)	
Total Example Cost	**$7460**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1205
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2132**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$500**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Emergency room care (including medical supplies)	
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therapy)	
Total Example Cost	**$2010**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$405
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1120**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
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BlueCross BlueShield of Kansas

Medical: BCBS of KS

You are eligible to participate in the medical benefit plan on the first of the month following date of hire. Eligible dependents may also participate; eligible dependents include dependent child(ren) to age 26 and under. Spousal coverage only available with completed affidavit form.

For questions concerning your medical benefits, a claim, to identify a network provider, or questions concerning your prescription drug coverage please contact BCBS of Kansas at 1-800-432-3990 or visit our website at www.bcbsks.com.

Option 2 - $1,000 Deductible - Rate Breakdown:

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$536.17	$1,151.58	$1,108.62	$1,724.04
Employer Pays	$289.53	$621.85	$598.66	$930.98
Employee Pays	$246.64	$529.73	$509.96	$793.06

Comprehensive Major Medical Grp: Ins: **Coverage Period: Beginning on or after 1/1/2018**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsks.com/blueaccess or call 1-800-432-3990. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsks.com/blueaccess or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Coinsurance is 20% to a max of **$2,500** person / **$5,000** family. Total out of pocket max is **$5,000** person / **$10,000** family. 20% non PPO penalty applies annually up to **$2,000** person / **$4,000** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsks.com /providerdirectory** or call 1-800-432-3990 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	$35 copay/visit	——————none——————
	Specialist visit	$35 copay/visit	$35 copay/visit	——————none——————
	Preventive care/screening/immunization	$0. Preventive is without cost share.	Deductible then 20% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsks.com	Generic drugs	$15 copay	$15 copay	——————none——————
	Preferred brand drugs	$30 copay	$30 copay	——————none——————
	Non-preferred brand drugs	$45 copay	$45 copay	——————none——————
	Specialty drugs	Copay as applicable on the above three categories	Not Covered	Specialty Drugs must be obtained from the Blue Cross and Blue Shield of Kansas Designated Specialty Pharmacy. If a Specialty Prescription Drug is obtained from a pharmacy other than our Designated Specialty Pharmacy, the drug will not be eligible for benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$100 copay then deductible and 20% coinsurance	$100 copay then deductible and 20% coinsurance	——————none——————
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
	Urgent care	$35 copay/visit	$35 copay/visit	Same as office visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	none
	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Habilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Skilled nursing care	Not Covered	Not Covered	none
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none
	Hospice services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	$35 copay/visit	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adult)	• Hearing aids	• Long-term care
• Weight loss programs		

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility treatment	• Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html	• Private-duty nursing
• Routine eye care (Adult)	• Routine foot care	• Spinal manipulations

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess, or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese		1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$1000**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood work)	
Specialist visit (anesthesia)	
Total Example Cost	**$12840**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1000
Copayments	$130
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3670**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$1000**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Primary care physician office visits (including disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glucose meter)	
Total Example Cost	**$7460**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1000
Copayments	$1205
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2632**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1000**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Emergency room care (including medical supplies)	
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therapy)	
Total Example Cost	**$2010**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1000
Copayments	$405
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1620**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

BlueCross BlueShield of Kansas

Medical: BCBS of KS

You are eligible to participate in the medical benefit plan on the first of the month following date of hire. Eligible dependents may also participate; eligible dependents include dependent child(ren) to age 26 and under. Spousal coverage only available with completed affidavit form.

For questions concerning your medical benefits, a claim, to identify a network provider, or questions concerning your prescription drug coverage please contact BCBS of Kansas at 1-800-432-3990 or visit our website at www.bcbsks.com.

Option 3 - $1,500 Deductible - Rate Breakdown:

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$522.64	$1,122.49	$1,080.63	$1,680.46
Employer Pays	$282.23	$606.14	$583.54	$907.45
Employee Pays	$240.41	$516.35	$497.09	$773.01

Blue Cross Blue Shield of Kansas **Comprehensive Major Medical** Grp: Ins: **Coverage Period: Beginning on or after 1/1/2018**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsks.com/blueaccess or call 1-800-432-3990. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsks.com/blueaccess or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/**$3,000** family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Coinsurance is 20% to a max of **$2,500** person / **$5,000** family. Total out of pocket max is **$5,000** person / **$10,000** family. 20% non PPO penalty applies annually up to **$2,000** person / **$4,000** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsks.com /providerdirectory** or call 1-800-432-3990 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	$35 copay/visit	——————none——————
	Specialist visit	$35 copay/visit	$35 copay/visit	——————none——————
	Preventive care/screening/immunization	$0. Preventive is without cost share.	Deductible then 20% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$0 up to $300 person, deductible then 20% coinsurance	$0 up to $300 person, deductible then 20% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsks.com	Generic drugs	$15 copay	$15 copay	——————none——————
	Preferred brand drugs	$30 copay	$30 copay	——————none——————
	Non-preferred brand drugs	$45 copay	$45 copay	——————none——————
	Specialty drugs	Copay as applicable on the above three categories	Not Covered	Specialty Drugs must be obtained from the Blue Cross and Blue Shield of Kansas Designated Specialty Pharmacy. If a Specialty Prescription Drug is obtained from a pharmacy other than our Designated Specialty Pharmacy, the drug will not be eligible for benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$100 copay then deductible and 20% coinsurance	$100 copay then deductible and 20% coinsurance	——————none——————
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——————none——————
	Urgent care	$35 copay/visit	$35 copay/visit	Same as office visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	——none——
	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Habilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Skilled nursing care	Not Covered	Not Covered	——none——
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——
	Hospice services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	——none——

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	$35 copay/visit	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adult)	• Hearing aids	• Long-term care
• Weight loss programs		

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility treatment	• Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html	• Private-duty nursing
• Routine eye care (Adult)	• Routine foot care	• Spinal manipulations

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess, or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

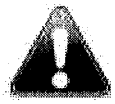
Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese		1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1500**	■ **The plan's overall deductible**	**$1500**	■ **The plan's overall deductible**	**$1500**
■ **Specialist copay**	**$35**	■ **Specialist copay**	**$35**	■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**	■ **Hospital (facility) coinsurance**	**20%**	■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**	■ **Other coinsurance**	**20%**	■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (prenatal care)		Primary care physician office visits (including disease education)		Emergency room care (including medical supplies)	
Childbirth/Delivery Professional Services		Diagnostic tests (blood work)		Diagnostic test (x-ray)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (ultrasounds and blood work)		Durable medical equipment (glucose meter)		Rehabilitation services (physical therapy)	
Specialist visit (anesthesia)					
Total Example Cost	**$12840**	**Total Example Cost**	**$7460**	**Total Example Cost**	**$2010**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1500	Deductibles	$1500	Deductibles	$1371
Copayments	$130	Copayments	$1205	Copayments	$405
Coinsurance	$2480	Coinsurance	$372	Coinsurance	$215
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$55	Limits or exclusions	$0
The total Peg would pay is	**$4170**	**The total Joe would pay is**	**$3132**	**The total Mia would pay is**	**$1991**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

BlueCross BlueShield of Kansas

Medical: BCBS of KS

You are eligible to participate in the medical benefit plan on the first of the month following date of hire. Eligible dependents may also participate; eligible dependents include dependent child(ren) to age 26 and under. Spousal coverage only available with completed affidavit form.

For questions concerning your medical benefits, a claim, to identify a network provider, or questions concerning your prescription drug coverage please contact BCBS of Kansas at 1-800-432-3990 or visit our website at www.bcbsks.com.

Option 4 - HDHP - Rate Breakdown:

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$476.16	$1,022.54	$984.42	$1,530.81
Employer Pays	$361.88	$777.13	$748.16	$1,194.03
Employee Pays	$114.28	$245.41	$236.26	$336.78

Employee eligible for Health Savings Account (HSA) with enrollment into HDHP medical benefit plan. If new enrollment for plan year, employee will receive separate HSA Enrollment Form for opening account with People's Bank, Ottawa Kansas from Payroll & Benefits Manager.

High Deductible Health Plan

Grp:
Ins:

Coverage Period: Beginning on or after 1/1/2018

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsks.com/blueaccess or call 1-800-432-3990. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsks.com/blueaccess or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Deductible is **$3,000** person/ **$6,000** family. Total out of pocket max is **$6,350** person / **$12,700** family. 20% non PPO penalty applies annually up to **$2,000** person / **$4,000** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsks.com /providerdirectory** or call 1-800-432-3990 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Questions: Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible then $0	Deductible then $0	——————none——————
	Specialist visit	Deductible then $0	Deductible then $0	——————none——————
	Preventive care/screening/immunization	$0. Preventive is without cost share.	Deductible then $0	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then $0	Deductible then $0	——————none——————
	Imaging (CT/PET scans, MRIs)	Deductible then $0	Deductible then $0	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsks.com	Generic drugs	Deductible then $15 copay	Deductible then $15 copay	——————none——————
	Preferred brand drugs	Deductible then $50 copay	Deductible then $50 copay	——————none——————
	Non-preferred brand drugs	Deductible then $75 copay	Deductible then $75 copay	——————none——————
	Specialty drugs	Copay as applicable on the above three categories	Not Covered	Specialty Drugs must be obtained from the Blue Cross and Blue Shield of Kansas Designated Specialty Pharmacy. If a Specialty Prescription Drug is obtained from a pharmacy other than our Designated Specialty Pharmacy, the drug will not be eligible for benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then $0	Deductible then $0	——————none——————
	Physician/surgeon fees	Deductible then $0	Deductible then $0	——————none——————
If you need immediate medical attention	Emergency room care	Deductible then $0	Deductible then $0	——————none——————
	Emergency medical transportation	Deductible then $0	Deductible then $0	——————none——————
	Urgent care	Deductible then $0	Deductible then $0	Same as office visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then $0	Deductible then $0	——————none——————
	Physician/surgeon fees	Deductible then $0	Deductible then $0	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then $0	Deductible then $0	——————none——————
	Inpatient services	Deductible then $0	Deductible then $0	——————none——————
If you are pregnant	Office visits	Deductible then $0	Deductible then $0	——————none——————
	Childbirth/delivery professional services	Deductible then $0	Deductible then $0	——————none——————
	Childbirth/delivery facility services	Deductible then $0	Deductible then $0	——————none——————
If you need help recovering or have other special health needs	Home health care	Deductible then $0	Deductible then $0	——————none——————
	Rehabilitation services	Deductible then $0	Deductible then $0	——————none——————
	Habilitation services	Deductible then $0	Deductible then $0	——————none——————
	Skilled nursing care	Not Covered	Not Covered	——————none——————
	Durable medical equipment	Deductible then $0	Deductible then $0	——————none——————
	Hospice services	Deductible then $0	Deductible then $0	——————none——————
If your child needs dental or eye care	Children's eye exam	Deductible then $0	Deductible then $0	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adult)	• Hearing aids	• Long-term care
• Weight loss programs		

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility treatment	• Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html	• Private-duty nursing
• Routine eye care (Adult)	• Routine foot care	• Spinal manipulations

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess, or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

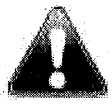
Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese		1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$3000**	■ **The plan's overall deductible**	**$3000**	■ **The plan's overall deductible**	**$3000**
■ **Specialist deductible**	**$3000**	■ **Specialist deductible**	**$3000**	■ **Specialist deductible**	**$3000**
■ **Hospital (facility) deductible**	**$3000**	■ **Hospital (facility) deductible**	**$3000**	■ **Hospital (facility) deductible**	**$3000**
■ **Other deductible**	**$3000**	■ **Other deductible**	**$3000**	■ **Other deductible**	**$3000**
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (prenatal care)		Primary care physician office visits (including disease education)		Emergency room care (including medical supplies)	
Childbirth/Delivery Professional Services		Diagnostic tests (blood work)		Diagnostic test (x-ray)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (ultrasounds and blood work)		Durable medical equipment (glucose meter)		Rehabilitation services (physical therapy)	
Total Example Cost	**$12840**	**Total Example Cost**	**$7460**	**Total Example Cost**	**$2010**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$3000	Deductibles	$3000	Deductibles	$1925
Copayments	$60	Copayments	$1115	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$55	Limits or exclusions	$0
The total Peg would pay is	**$3120**	**The total Joe would pay is**	**$4170**	**The total Mia would pay is**	**$1925**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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BlueCross BlueShield of Kansas
Blue Choice Network

Elizabeth Layton Center

BlueCare DentalPlus PPO

Effective Jan 1, 2018

This Dental Care Program offers complete coverage for in-network preventive services, along with additional coverage for primary and major dental services from in-network dentists. Employees and each eligible dependent will receive a maximum of $1,500 in benefits for all covered services each anniversary year.

In-Network	Out-of-Network	Covered Services
	PREVENTIVE	
No deductible **100% payment**	**Deductible then 80/20**	Oral examinations Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue and cavity detection Fluoride (under age of 21) Prophylaxis, including cleaning, scaling and polishing Sealants limited to one application per lifetime per eligible insured between 5 and 17 years of age inclusive, and limited to permanent molars and bicuspids Space maintainers
	PRIMARY	
Primary and Major Dental benefits have a combined deductible maximum of $50/individual. **80% payment**	**Primary and Major Dental benefits have a combined deductible maximum of $200/individual.** **70% payment**	Inlays Simple extractions Repair of dentures Fillings (except gold) Emergency treatment for pain Endodontics General anesthesia when the dental treatment is covered Periodontics, non-surgical Non-surgical care of acute oral infection and oral lesions Oral surgery, consisting of diagnosis and treatment of fractures.
	MAJOR	
Following a 240 day waiting period, Primary and Major Dental benefits have a combined deductible maximum of $50/individual. **50% payment**	**Following a 240 day waiting period, Primary and Major Dental benefits have a combined deductible maximum of $200/individual.** **40% payment**	Periodontal surgery Surgery of the bony structure supporting the teeth * Bridges * Onlays (not part of a bridge) * Crowns (not part of a bridge) * Dentures, full or partial * Dental implant services ($1,000 lifetime max per insured, per arch)
	ORTHODONTIC RIDER (under age of 21)	
100% payment subject to maximums **18 month maximum** of $150** **Yearly maximum** of $750 and a 3-yr max of $1,500** **$150 maximum** not to exceed one such payment in any 5-yr period**	**100% payment subject to maximums** **18 month maximum** of $150** **Yearly maximum** of $750 and a 3-yr max of $1,500** **$150 maximum** not to exceed one such payment in any 5-yr period**	Retention treatment Active treatment, including necessary appliances Diagnosis including study models and facial photographs
	TEETH WHITENING	
$200 applied to annual maximum	**Not covered**	

** If orthodontic treatment begins before the effective date of this rider, the months of previous treatment will be deducted from the maximum number of months available under this program.

Note: Any charges for the replacement and/or repair of any appliance previously furnished under this plan shall not be covered by Blue Cross and Blue Shield of Kansas.

Benefits are not provided for denture or bridge replacement within five years after receiving dentures or bridges under this program. Benefits are limited to standard procedures for prosthodontic services.

Contracting Dentists: Payment will be the maximum allowable charge for covered dental services. Payment will be sent directly to the dentist. The member will only be responsible for any coinsurance amount:, and any charges for non-covered services.

Out-of-Network Dentists In Company Service Arca: The maximum allowance paid will be 80 percent for preventive services and 70 percent for primary services of the allowance paid to a non contracting dentist for the same service. The member wm be responsible for the remaining 20 percent for preventive and 30 percent for primary services. The member will also be responsible for any difference between the payment allowance and the provider's charge, in addition to any coinsurance amounts and any charges for non-covered services. Payment will be sent directly to the member.

Coinsurance: The coinsurance will be applied to the payments of a contracting dentist or a non-contracting dentist as described.

Exclusions: Services not listed a:: eligible dental services in the certificate; duplicate benefits provided under federal, state or local laws, regulations or programs {except for l\lcdicaid); patient education services; ho::pital call:: and consultations; lab work; occlusal adju::tmcnts; dental implants (except limited coverage under Prosthodontics); services for diseases or injuries caused by or arising out of acts of acts of war or aggression; service:: for cosmetic purposes; payment:- under any provi,ion of a Blue Cross and Blue Shield of Kansas certificate when the payment would duplicate payment for coverage made under another provi::ion of the dental certificate (but only to the extent that such payment would exceed the charge for the service); :-ervices provided by a dentist for which there would customarily be no charge; medically unnecessary :-ervices; service:, related to alveolar ridge augmentations; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; orthodontic ::ervices; $Crvices covered and payable by any medical expense payment provision of any automobile insurance policy; service:, performed by imme<liate relative:: or by member:: of the hou:,ehold of the employee; benefits received when a patient transfer:- during treatment, or if more than one dentist provide:, services for the same, payment for that benefit wiH not exceed the amount payable for one service.

This is a brief :-ummary of the coverage available under this program. It is not a legal document.
The exact provisions of the benefits and exclusions are contained in the certificate.

BlueCross BlueShield of Kansas

Dental: BCBS of KS

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$26.07	$55.86	$58.86	$88.65
Employer Pays	$11.73	$11.17	$11.77	$13.30
Employee Pays	$14.34	$44.69	$47.09	$75.35

GUARDIAN®

Vision: Guardian

Annual eye exams are important to your overall health. During your eye exam, a VSP doctor will look for vision problems and signs of other health conditions like diabetic eye disease, high blood pressure, and high cholesterol. You are eligible to participate in the employee benefits on the first of the month following date of hire. Eligible dependents may also participate. Eligible dependents include your legal spouse and/or dependent child(ren) to age 25.

To identify participating doctors, you may call Guardian at 800-627-4200 or visit their website at guardiananytime.com.

PPO Network	Network
Eye Exam (once every 12 months)	$10 copay (Inclusive with materials copay)
Lenses Single: (once every 12 months)	$25 copay
Bifocal/Trifocal	$25 copay
Frames: (once every 24 months)	$130 allowance
Contacts Lenses Elective:	$130 allowance in lieu of spectacle then 15% off

Rates – Per Month	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Total Premium	$6.66	$11.23	$11.43	$18.11
Employer Pays	$6.66	$6.66	$6.66	$6.66
Employee Pays	$0.00	$4.57	$4.77	$11.45

Voluntary Critical Illness: Guardian

BENEFITS			
Contribution/ Participation	Voluntary/Minimum participation 2 enrolled		
Employee Critical Illness Benefit Amounts	Employee may choose a lump sum benefit of $5,000 to $15,000 in increments of $5,000		
Dependent Critical Illness Benefit Amounts	Spouse: $5,000	Child: 25% of Employee Benefit	
Covered Conditions (lump sum payments)		**First Occurrence**	**Second Occurrence**
	Cancer		
	Invasive Cancer	100%	50%
	Carcinoma In Situ	30%	0%
	Benign Brain Tumor	75%	0%
	Skin Cancer	$250 per lifetime	Not included

Covered Conditions (lump sum payments)		**First Occurrence**	**Second Occurrence**
	Vascular		
	Heart Attack	100%	50%
	Stroke	100%	50%
	Heart Failure	100%	50%
	Arteriosclerosis	30%	0%
	Other		
	Organ Failure	100%	50%
	Kidney Failure	100%	50%
Group 2 Covered Conditions	First Occurrence of these additional illnesses: Addison's Disease 30%, ALS (Lou Gehrig's Disease) 100%, Alzheimer's Disease 50%, Coma 100%, Huntington's Disease 30%, Multiple Sclerosis 30%, Loss of Speech, Sight or Hearing 100%, Parkinson's Disease 100%, Permanent Paralysis 50% for 1 limb, 100% for 2 limbs, Severe Burns 100%		
Group 3 Childhood Covered Conditions	100% of Child Benefit for the First Occurrence of Cerebral Palsy, Cleft lip/palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes		
Cancer Vaccine	$50 per lifetime for receiving a Cancer Vaccine		
Wellness Benefit	Provides a per year benefit for completing certain routine wellness screenings or procedures (refer to plan highlights for listing). Employee $75; Spouse $75; Child $75		
Dependent Age Limits	Child birth to 26 years		
Pre-Existing Condition Limitation	3 month look back period, 12 month exclusion period 3 month look back period, 6 months treatment free, 12 month exclusion period (TX & VA)		
Benefit Reduction (of original amount)	None		

Monthly Premium						
Employee						
Benefit Amounts	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$5,000	$6.35	$7.80	$12.35	$20.35	$29.85	$55.75
$10,000	$9.70	$12.60	$21.70	$37.70	$56.70	$108.50
$15,000	$13.05	$17.40	$31.05	$58.70	$83.55	$161.25
Spouse						
Benefit Amounts	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$5,000	$6.35	$7.80	$12.35	$20.35	$29.85	$55.75

Rate Guarantee	2 Years				
Premiums	Premiums listed are for Issue Age and will not increase due to an insured's age. Child cost is included with employee election.				
Underwriting Requirements	**Employee <70**	**Spouse <70**	**Child**	**Employee 70+**	**Spouse 70+**
Guarantee Issue	$15,000	$5,000	All amounts Guaranteed	Health questions required.	Health questions required.

Voluntary Accident: Guardian

BENEFITS			
	Value Plan	Advantage Plan	Premier Plan
Accident Coverage	Off Job	Off Job	Off Job
Accidental Death and Dismemberment			
Death Benefit	N/A	Employee: $25,000 Spouse: $10,000 Child: $5,000	Employee: $50,000 Spouse: $25,000 Child: $10,000
Catastrophic Loss	N/A	Quadriplegia: 100% of AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D	Quadriplegia: 100% of AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D
Common Carrier	N/A	200% of AD&D	200% of AD&D
Common Disaster	N/A	200%of Spouse AD&D benefit	200%of Spouse AD&D benefit
Hand, Foot, Sight	N/A	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	N/A	25% of AD&D	25% of AD&D
Seatbelts and Airbags	N/A	Seatbelts: $10,000 Airbags: $15,000	Seatbelts: $10,000 Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	N/A	$2,500	$2,500
Wellness Benefit	Provides a $50 per year benefit for completing certain routine wellness screenings or procedures (refer to Plan Highlights section for example procedures)	Provides a $50 per year benefit for completing certain routine wellness screenings or procedures (refer to Plan Highlights section for example procedures)	Provides a $50 per year benefit for completing certain routine wellness screenings or procedures (refer to Plan Highlights section for example procedures)

BENEFITS (continued)

	Value Plan	Advantage Plan	Premier Plan
Accident Emergency Treatment	$150	$175	$200
Accident Follow-Up Visit - Doctor	$25 up to 6 treatments	$50 up to 6 treatments	$75 up to 6 treatments
Air Ambulance	$500	$1,000	$1,500
Ambulance	$100	$150	$200
Appliance	$100	$125	$125
Blood/Plasma/Platelets	$300	$300	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn – Skin Graft	50% of burn benefit	50% of burn benefit	50% of burn benefit
Child Organized Sport	20% increase to child benefits	20% increase to child benefits	20% increase to child benefits
Chiropractic Visits	No Benefit	$25 per visit up to 6 visits	$50 per visit up to 6 visits
Coma	$7,500	$10,000	$12,500
Concussions	$50	$75	$100
Dislocations	Schedule up to $3,600	Schedule up to $4,400	Schedule up to $4,800
Diagnostic Exam (Major)	$100	$150	$200
Emergency Dental Work	$200/Crown $50/Extraction	$300/Crown $75/Extraction	$400/Crown $100/Extraction
Epidural pain management	$100, 2 times per accident	$100, 2 times per accident	$100, 2 times per accident
Eye Injury	$200	$300	$300
Family Care	$20/day up to 30 days	$20/day up to 30 days	$20/day up to 30 days
Fracture	Schedule up to $4,500	Schedule up to $5,500	Schedule up to $6,000
Hospital Admission	$750	$1,000	$1,250
Hospital Confinement	$175/day, up to 1 yr	$225/day, up to 1 yr	$250/day, up to 1 yr
Hospital ICU Admission	$1,500	$2,000	$2,500
Hospital ICU Confinement	$350/day – up to 15 days	$450/day – up to 15 days	$500/day – up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$50	$75	$100
Knee Cartilage	$500	$500	$750
Joint Replacement (hip/knee/shoulder)	$1,500/$750/$750	$2,500/$1,250/$1,250	$3,500/$1,750/$1,750
Laceration	Schedule up to $300	Schedule up to $400	Schedule up to $500
Lodging	$100/day, up to 30 days for companion hotel stay	$125/day, up to 30 days for companion hotel stay	$150/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days	$25/day up to 10 days	$35/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000	1: $500 2 or more: $1,000	1: $750 2 or more: $1,500
Rehabilitation Unit Confinement	$150/day up to 15 days	$150/day up to 15 days	$150/day up to 15 days
Ruptured Disc with Surgical Repair	$500	$500	$750
Surgery (Cranial, Open Abdominal, Thoracic)	$1,000 Hernia: $125	$1,250 Hernia: $150	$1,500 Hernia: $200
Surgery – Exploratory or Arthroscopic	$150	$250	$350
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500	1: $500 2 or more: $1,000	1: $750 2 or more: $1,500
Transportation	$400, 3 times per accident	$500, 3 times per accident	$600, 3 times per accident
X-Ray	$20	$30	$40

IMPORTANT INFORMATION

- Available on groups with 2+ eligible lives (Bukaty Clients Only)
- Not available in AK, CA, CT, ID, MD, MN, ND, NH, NM, NY, VT, WA. Only available in FL for groups with 50+ eligible lives.

MONTHLY RATES

	Value Plan	Advantage Plan	Premier Plan
Employee	$14.00	$19.00	$24.00
Employee & Spouse	$26.00	$33.00	$40.00
Employee & Child	$26.00	$33.00	$40.00
Family	$36.00	$47.00	$56.00

Rate Guarantee	2 Years
Contributory Status	Voluntary
Minimum Participation	2 enrolled employees
Portability	Included without evidence (Not available in LA or ME)
Child(ren) Age Limits	Birth to 26 yrs (26 if full-time student), subject to state limitations

Basic Life and AD&D: Guardian

GUARDIAN

Coverage is provided by Elizabeth Layton Center and is effective on the first of the month following date of hire.

Benefit	
Employee	$15,000 Basic Term life Insurance

Voluntary Term Life/AD&D: Guardian

GUARDIAN

You also have the option of purchasing additional life insurance for yourself, your spouse, and your eligible dependents. You are eligible for benefits on the first day of the month following your date of hire. Dependent children are eligible to age 26*.

Benefit schedule - Employee	You can choose employee coverage in $10,000 units, from a minimum of $20,000 up to 5 times your basic annual pay, but not more than $500,000.
Benefit Schedule - Spouse/Child(ren)	If you cover yourself, you can also purchase Voluntary Life Insurance for your eligible family members. Spouse - You can buy spouse coverage in units of $5,000, up to the lesser of 50% of your own coverage amount or $250,000. Child(ren) - You can buy coverage for your children too - in an amount of $5,000, or $10,000. The 50% limit also applies to child coverage. You can also buy AD&D coverage for your dependents, if you buy AD&D coverage for yourself. The Dependent AD&D amount will match the Dependent Life amount.
Guaranteed issue	$100,000 for yourself, up to $20,000 for your spouse, and up to $10,000 for each child without answering health questions. To enroll for more coverage than the amounts shown above, you'll need to answer a simple health statement.

Age of Employee or Spouse	Monthly Premium Per $10,000 of Life Insurance – Non-Tobacco User and Spouse	Monthly Premium per $10,000 of Life Insurance – Tobacco User
Less than 30	$.058	$0.98
30 but less than 35	$0.56	$1.12
35 but less than 40	$0.76	$1.59
40 but less than 45	$1.17	$2.52
45 but less than 50	$1.88	$4.07
50 but less than 55	$3.04	$6.41
55 but less than 60	$4.16	$9.57
60 but less than 65	$5.85	$11.00
65 but less than 70	$10.43	$15.43
Age 70 and over (employee only)	$19.18	$29.34

Long-Term Disability: Guardian

GUARDIAN

Coverage is provided by Elizabeth Layton Center and is effective on the first of the month following date of hire.

Benefit	
Benefit Percentage	60% of your monthly salary, subject to a maximum amount of $5,600
Minimum Benefit	$100
Elimination Period	90 calendar days of disability caused by the same or a related sickness or injury

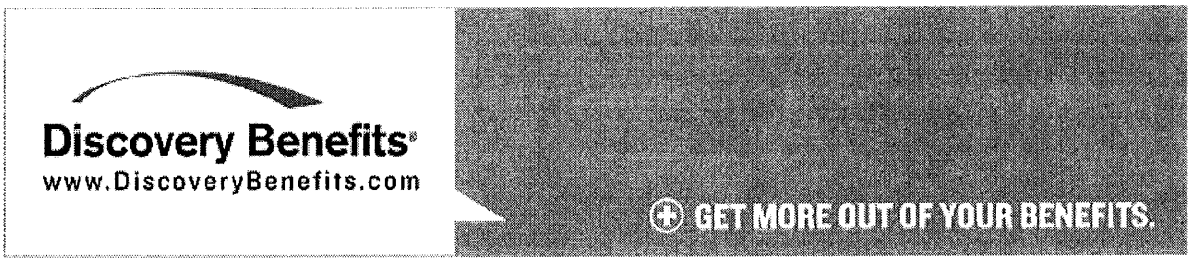
Short-Term Disability: Guardian

GUARDIAN

Coverage is provided by Elizabeth Layton Center and is effective on the first of the month following date of hire.

Benefit	
Benefit Amount	60% of your weekly salary, subject to a maximum amount of $700 per week.
Waiting Period	1st day accident /7 days sickness
Benefit Duration Maximum	13 weeks

***Guardian Certificate states –**
Your eligible dependents are: (a) your legal spouse; (b) your unmarried dependent children who are under age 26; and (c) your unmarried dependent children from age 26 until their 26th birthday, who are enrolled as full-time students at accredited schools. An unmarried dependent child who is not able to remain enrolled as a full-time student due to a medically necessary leave of absence may continue to be an eligible dependent until the earlier of: (a) the date that is one year after the first day of the medically necessary leave of absence; or (b) the date on which coverage would otherwise end under this plan. You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.



Flexible Spending Account (FSA)

Plan Year: January 1, 2018-December 31, 2018

A Flexible Spending Account (FSA) allows employees to set aside a portion of their salary (before taxes) to pay for qualified medical or dependent care expenses.
Three types of FSA plans are available:

- ***Medical FSA*** - An FSA that is used in addition to traditional insurance plans. A Medical FSA is used to cover expenses like co-insurance, prescription medications, and medical equipment that are not covered by the traditional insurance plan.
    - *Current IRS Guidelines allow an employee to contribute up to $2,650 maximum*

Carryover – For Employee's enrolled in 2017 Medical FSA
For Medical FSAs and Limited Medical FSAs, if additional funds remain in the participant's account after the end of the plan year and after the run-out period has elapsed, those additional funds can be carried over into the next plan year (if the participant is enrolled in the FSA in next year). IRS guidelines allow up to $500 maximum to carryover at the end of a plan year. Carryover is only available for Medical FSA. The debit card will continue to work as normal, using the funds that are carried over in addition to the participant's election amount in their next plan year.

- ***Dependent Care FSA*** - An FSA that dedicates a portion of an employee's paycheck for dependent care for children up to age 13, a disabled dependent of any age, or a disabled spouse. To be eligible for this type of plan, the participant and spouse (if applicable) must be actively working, seeking work, or be full-time students. The Dependent Care FSA can be used in conjunction with HDHPs or traditional insurance plans.
    - *Current IRS Guidelines allow an employee to contribute up to $5,000 maximum,*

- ***Limited Medical FSA*** - An FSA for use with a high deductible health plan (HDHP) and a health savings plan (HSA). The Limited Medical FSA covers dental and vision expenses only.
    - *Current IRS Guidelines allow an employee to contribute up to $2,650 maximum,*

Grace Period
A plan allows a "Grace Period" of up to 2 months and 15 days after the end of a plan year to incur expenses and pay for them, using money from the previous plan year.

Benefits Debit Card
A Discovery Benefits debit card allows participants to pay for medical services, equipment, prescriptions, or other eligible expenses directly from their FSA, without needing to wait for reimbursement.
Under IRS regulation, debit card transactions need to be monitored to ensure that they are used for eligible expenses only. On occasion, Discovery Benefits might reach out to a participant and request documentation and/or receipts to substantiate the debit card transactions.
Some expenses can be automatically substantiated when they are purchased with the Benefits debit card. The following features assist with auto-substantiation:

- *Inventory Information Approval System (IIAS)* - A system that is used by many big box retailers (like Target, Walmart, CVS, and Walgreens), where the card recognizes the merchant code that is associated the facility. The card then processes and approves all eligible expenses at these facilities, and no additional documentation is required.

(Benefits Debit Card continued)

- *Recurring expenses* - A series of eligible expenses that occur with the same provider and for the same amount (like regular chiropractor visits). The first such expense must be substantiated, but subsequent expenses to the same facility or provider for the same amount are automatically substantiated.
- *Co-payments* - Flat dollar co-pay amounts that are associated with the participant's FSA and are applied to the card. When the debit card is used at a qualified medical facility for these co-pay amounts (like a $25 co-pay for an office visit), the card automatically approves the transaction and no additional documentation is required.

Additional Information

- Employee must re-enroll for these benefits each plan year.
- If you have outstanding expenses or incur FSA eligible expenses on or before 03/15/2019, they must be filed by no later than 03/31/2019.
- Be conservative in your estimated, because the IRS has a "use it or lose it" rule, where you lose your any leftover balance at the end of the plan year. New carryover law now allows for $500 carryover into the new plan year if the participant is enrolled in the FSA in next year.
- Claims must be incurred during the plan year and grace period (January 1 – March 2019) to be eligible for reimbursement from your flexible spending account. Incurred means the date you receive the services, not when you are billed or pay for the service.
- If you have a Health Savings Account, you are only eligible to have a Limited Flexible Spending Account which covers dental and vision expenses only.

BUKATY ONLINE ENROLLMENT

Benefit Enrollment Has Never Been Easier

NEW USER ENROLLMENT PROCESS

What you will need:

Please have the following information available when you enroll:

- Your date of birth and SSN
- Your home address, telephone number and email address
- Eligible dependents' names, dates of birth and SSNs
- Beneficiary information

Step 1: Getting Started

www.bukaty.com/online-enrollment

Step 2: How to Register & Enroll

- Click on ***New User Registration***
- Date of Birth: MM/DD/YYYY
- Company Identifier:
- Username MUST be an email address *(Personal or work)*
- Create password
- Once logged into the system, it will take you to your home screen.

Step 3: Begin Enrollment

- Click on the ***Start Benefits*** tab and complete your personal information page

- Complete all Dependent information if applicable
- Make your enrollment selections for each coverage provided
- If you are waiving coverage you must select the decline enrollment option
- Click ***Save & Continue*** or ***Don't want this benefit?*** after each section

Step 4: Complete Enrollment

- In the summary tab, review enrollment elections for accuracy and click ***Agree*** to confirm your enrollment
- Your enrollment process is now complete and you may log in at any time to access all your benefit information

EXISTING USER ENROLLMENT PROCESS

What you will need:

Please have the following information available when you enroll:

- Eligible dependents' names, dates of birth and SSNs
- Beneficiary information

Step 1: Getting Started

www.bukaty.com/online-enrollment

Step 2: How to Log in as an Existing User

- Enter Username and Password to login
  - If you need your Username and Password reset, contact enrollmentsupport@bukaty.com
- Once logged into the system, it will take you to your home screen

Step 3: Begin Enrollment

- Click on the ***Start Benefits*** tab and complete your personal information page

- Complete all Dependent information if applicable
- Make your enrollment selections for each coverage provided
- If you are waiving coverage you must select the decline enrollment option
- Click ***Save & Continue*** or ***Don't want this benefit?*** after each section

Step 4: Complete Enrollment

- In the summary tab, review enrollment elections for accuracy and click ***Agree*** to confirm your enrollment
- Your enrollment process is now complete and you may log in at any time to access all your benefit information

For assistance please contact
the Benefit Enrollment Team at
enrollmentsupport@bukaty.com

25 YEARS
BUKATY
COMPANIES

Elizabeth Layton Center, Inc.

2018 Health, Dental, & Vision Insurance Premiums

		Deduction		Benefit		
Blue Cross Blue Shield Kansas		**Employee**	Employee	ELC	ELC	**Total**
Traditional $500 Deductible Health Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	**Cost**
MED E	Employee	**127.16**	254.32	298.55	149.28	**$ 552.87**
MED ES	Employee/Spouse	**273.12**	546.23	641.23	320.62	**$ 1,187.46**
MED EC	Employee/Child	**262.93**	525.86	617.32	308.66	**$ 1,143.18**
MED F	Employee/Family	**408.89**	817.78	960.00	480.00	**$ 1,777.78**

		Deduction		Benefit		
Blue Cross Blue Shield Kansas		**Employee**	Employee	ELC	ELC	**Total**
Traditional $1000 Deductible Health Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	**Cost**
MED E-2	Employee	**123.32**	246.64	289.53	144.77	**$ 536.17**
MED ES-2	Employee/Spouse	**264.87**	529.73	621.85	310.93	**$ 1,151.58**
MED EC-2	Employee/Child	**254.99**	509.97	598.66	299.33	**$ 1,108.63**
MED F-2	Employee/Family	**396.53**	793.06	930.98	465.49	**$ 1,724.04**

		Deduction		Benefit		
Blue Cross Blue Shield Kansas		**Employee**	Employee	ELC	ELC	**Total**
Traditional $1500 Deductible Health Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	**Cost**
MED E-3	Employee	**120.21**	240.41	282.23	141.12	**$ 522.64**
MED ES-3	Employee/Spouse	**258.18**	516.35	606.14	303.07	**$ 1,122.49**
MED EC-3	Employee/Child	**248.55**	497.09	583.54	291.77	**$ 1,080.63**
MED F-3	Employee/Family	**386.51**	773.01	907.45	453.73	**$ 1,680.46**

		Deduction		Benefit		
Blue Cross Blue Shield Kansas		**Employee**	Employee	ELC	ELC	**Total**
High Deductible Health Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	**Cost**
MED2 E	Employee	**57.14**	114.28	361.88	180.94	**$ 476.16**
MED2ES	Employee/Spouse	**122.71**	245.41	777.13	388.57	**$ 1,022.54**
MED2EC	Employee/Child	**118.13**	236.26	748.16	374.08	**$ 984.42**
MED2EF	Employee/Family	**168.39**	336.78	1194.03	597.02	**$ 1,530.81**

		Deduction		Benefit		
Blue Cross Blue Shield Kansas		**Employee**	Employee	ELC	ELC	Total
Dental Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	Cost
DEN EE	Employee	**7.17**	14.34	11.73	5.87	**$ 26.07**
DEN ES	Employee/Spouse	**22.35**	44.69	11.17	5.59	**$ 55.86**
DEN EC	Employee/Child	**23.55**	47.09	11.77	5.89	**$ 58.86**
DEN F	Employee/Family	**37.68**	75.35	13.3	6.65	**$ 88.65**

		Deduction		Benefit		
		Employee	Employee	ELC	ELC	Total
Gaurdian/VSP Vision Plan		**Per Pay Period**	Per Month	Per Month	Per Pay Period	Cost
VIS	Employee		$ -	6.66	3.33	$ 6.66
VIS ES	Employee/Spouse	**2.29**	$ 4.57	6.66	3.33	$ 11.23
VIS EC	Employee/Child	**2.39**	$ 4.77	6.66	3.33	$ 11.43
VIS EF	Employee/Family	**5.73**	$ 11.45	6.66	3.33	$ 18.11

			Benefit		
			ELC	ELC	Total
ELC $15,000 Life Insurance & AD&D Benefit			Per Month	Per Pay Period	Cost
LIFE BEN	Life Insurance benefit		2.85	1.425	$ 2.55

ELIZABETH LAYTON CENTER

For Hope and Guidance

Spousal Healthcare Affidavit

(Required only if you wish to cover your spouse under Elizabeth Layton Center's Blue Cross Blue Shield of Kansas Healthcare plan)

Name of Employee:_____

Name of Spouse:_____

Important: Please ensure this form is fully completed.
Your response, or lack of response, will impact the medical coverage of your spouse.

If you are an Elizabeth Layton Center employee who has selected medical coverage for your spouse, you must complete this form. If applicable, your spouse's employer must compete Section II.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

- ☐ Yes, at an employer **other than** Elizabeth Layton Center, Inc (continue to Section II)
- ☐ Yes, at Elizabeth Layton Center, Inc (continue to Section III)
- ☐ Self-employed (continue to Section II)
- ☐ Not employeed/Retired (continue to Section III)

Please note that if your spouse's employer provides qualifying group medical coverage, your spouse must enroll in the spouse's employer's plan. Your spouse will no longer be eligible for coverage under Elizabeth Layton Center's medical plan, effective January 1, 2017. This loss of eligibility would be considered a "qualifying event" allowing your spouse to enroll in coverage with the spouse's employer.

SECTION II: Employer Certification of Spouse's Health Benefit Coverage

Note: This section must be completed in full by <u>your spouse's employer.</u>

1. Is the spouse named above eligible for qualifying group medical coverage through your company? ☐ YES ☐ NO
2. If you answered no to the previous question, will he/she become eligible at a later date? ☐ YES ☐ NO
   - If yes, please provide the date they will become eligible for coverage:_____

Name of Employer:_____

Address of Employer_____

Name of Representative (Printed):_____ Phone:_____

Signature of Representative:_____

Title:_____ Date:_____

SECTION III: Acknowledgement—must be signed by above-named Elizabeth Layton Center, Inc. Employee

I certify that the foregoing is true, correct and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action. I further acknowledge that it is my responsibility to notify the Payroll and Benefits Manager if, at any future date, the information provided above changes.

_____ _____

Employee Signature (required) Date

Please return to Christy Sallee, Payroll and Benefits Manager at 2537 Eisenhower, Ottawa KS location.
<u>This form will need to be received before proceeding with Employee Navigator online enrollment.</u>

Discovery Benefits®
www.DiscoveryBenefits.com

Flexible Spending Account (FSA)

Plan Year: January 1, 2018-December 31, 2018

A Flexible Spending Account (FSA) allows employees to set aside a portion of their salary (before taxes) to pay for qualified medical or dependent care expenses.
Three types of FSA plans are available:

- ***Medical FSA*** - An FSA that is used in addition to traditional insurance plans. A Medical FSA is used to cover expenses like co-insurance, prescription medications, and medical equipment that are not covered by the traditional insurance plan.
    - *Current IRS Guidelines allow an employee to contribute up to $2,650 maximum*

Carryover – For Employee's enrolled in 2017 Medical FSA
For Medical FSAs and Limited Medical FSAs, if additional funds remain in the participant's account after the end of the plan year and after the run-out period has elapsed, those additional funds can be carried over into the next plan year (if the participant is enrolled in the FSA in next year). IRS guidelines allow up to $500 maximum to carryover at the end of a plan year. Carryover is only available for Medical FSA. The debit card will continue to work as normal, using the funds that are carried over in addition to the participant's election amount in their next plan year.

- ***Dependent Care FSA*** - An FSA that dedicates a portion of an employee's paycheck for dependent care for children up to age 13, a disabled dependent of any age, or a disabled spouse. To be eligible for this type of plan, the participant and spouse (if applicable) must be actively working, seeking work, or be full-time students. The Dependent Care FSA can be used in conjunction with HDHPs or traditional insurance plans.
    - *Current IRS Guidelines allow an employee to contribute up to $5,000 maximum,*

- ***Limited Medical FSA*** - An FSA for use with a high deductible health plan (HDHP) and a health savings plan (HSA). The Limited Medical FSA covers dental and vision expenses only.
    - *Current IRS Guidelines allow an employee to contribute up to $2,650 maximum,*

Grace Period
A plan allows a "Grace Period" of up to 2 months and 15 days after the end of a plan year to incur expenses and pay for them, using money from the previous plan year.

Benefits Debit Card
A Discovery Benefits debit card allows participants to pay for medical services, equipment, prescriptions, or other eligible expenses directly from their FSA, without needing to wait for reimbursement.
Under IRS regulation, debit card transactions need to be monitored to ensure that they are used for eligible expenses only. On occasion, Discovery Benefits might reach out to a participant and request documentation and/or receipts to substantiate the debit card transactions.
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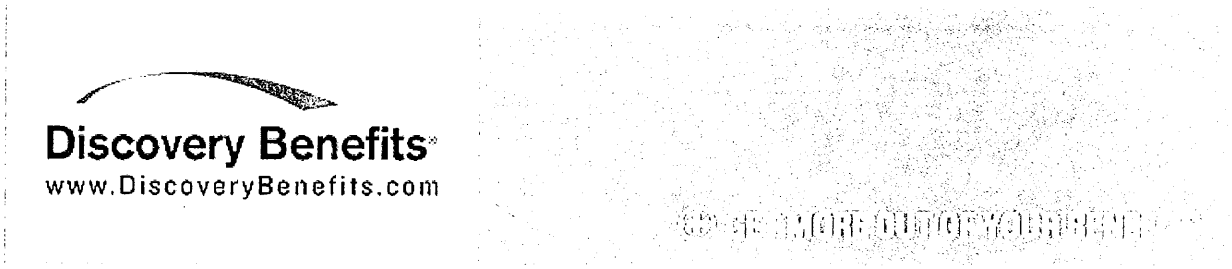

(Benefits Debit Card continued)

- *Recurring expenses* - A series of eligible expenses that occur with the same provider and for the same amount (like regular chiropractor visits). The first such expense must be substantiated, but subsequent expenses to the same facility or provider for the same amount are automatically substantiated.
- *Co-payments* - Flat dollar co-pay amounts that are associated with the participant's FSA and are applied to the card. When the debit card is used at a qualified medical facility for these co-pay amounts (like a $25 co-pay for an office visit), the card automatically approves the transaction and no additional documentation is required.

Additional Information

- Employee must re-enroll for these benefits each plan year.
- If you have outstanding expenses or incur FSA eligible expenses on or before 03/15/2019, they must be filed by no later than 03/31/2019.
- Be conservative in your estimated, because the IRS has a "use it or lose it" rule, where you lose your any leftover balance at the end of the plan year. New carryover law now allows for $500 carryover into the new plan year if the participant is enrolled in the FSA in next year.
- Claims must be incurred during the plan year and grace period (January 1 – March 2019) to be eligible for reimbursement from your flexible spending account. Incurred means the date you receive the services, not when you are billed or pay for the service.
- If you have a Health Savings Account, you are only eligible to have a Limited Flexible Spending Account which covers dental and vision expenses only.

Health Savings Account –
Eligible with High Deductible Health Plan

Your Personal HSA Bank Account

You may contribute to your account on a pre-tax basis through payroll deduction. (Consider taking the payroll deduction savings and automatically funding your HSA.)

Always use your health plan ID card to receive network discounts.

Your account is portable. If you leave ELC you keep the HSA. Unused funds roll over year-to-year, are portable and are owned by the individual (acts like a Medical IRA).

Individuals with other coverage (including FSA) may not be eligible for an HSA. You may enroll in a limited purpose FSA for unreimbursed dental and vision expenses only.

Individuals age 65+ and entitled to Medicare are not eligible for an HSA.

High Deductible Health Plan

In-Network Annual Deductible and Maximum Out of Pocket:

Ind. $3,450 Family $6,900

After deductible, eligible expenses are paid at 100%.

Plan includes certain specified preventive care services paid at 100% before the deductible applies.

Note: If you have other coverage or are covered under your spouse's FSA you may not be eligible for the HSA portion of the program. Refer to plan information for any exclusions or limitations that may apply.

Health Savings Account Considerations

- You can **change your contributions** during the year (unlike the flexible spending account).
- The **overall out of pocket maximum is less** under the HDHP than the $500 deductible plan due to copays.
- **All eligible plan expenses will count toward your deductible** (under the base plan any copay costs do not count toward the deductible or maximum out of pocket).
- **No use it or lose it!**
- **Portability** – if you leave employment you take the HSA fund with you.
- **Tax Savings** - Your contributions to the HSA are tax deductible, so you'll pay less in income taxes.
- **Control** – You can use the HSA to pay for any qualified medical expense, as defined by the IRS.
- **Savings and Investments** – Unlike premiums, unused HSA dollars remain in the HSA until you use them. Funds may be invested to earn interest on a tax-preferred basis. You have the right to direct your own account and may move funds into any qualified custodial account of your choice.
- **Convenience of payroll deduction.** ELC will automatically withhold your contribution on a pre-tax basis and immediately fund your personal Health Savings Account. HSA account will be held at People's Bank Ottawa, KS.

Important Information for Health Savings Accounts

- The Health Savings Account (HSA) is a special tax-advantaged savings account. Funds deposited into the account are intended to be used to pay for qualified medical expenses. Qualified medical expenses are found in IRS Publication 502, available on-line at **www.irs.gov** and are generally the same expenses as those that individual taxpayers can deduct on their federal tax returns.

- Contributions to HSAs are tax deductible, grow tax free and the distributions are never taxed so long as the funds are used for qualified medical expenses.

- Unused money rolls over to the next year and is fully portable. (No use it or lose it!)

- You *may not* be eligible to fund an HSA if you have other health insurance coverage. The other coverage could be through your spouse's employment, VA coverage, Tricare, Medicare or coverage through a spouse's flexible spending account. You are not eligible if you can be claimed as a dependent on another individual's tax return.

- **ELC has selected People's Bank to administer the HSAs. You may fund the account with pre-tax payroll deductions that will be forwarded to the bank; or you may fund the account on your own and take an above-the-line tax deduction when you file your income taxes. You have until the tax filing deadline, April 15th, to fund any or all of your account.**

- You are responsible for keeping records of expenses that qualify for reimbursement from the HSA, and for documenting those expenses in the event you are audited by the IRS. BCBS KS and Delta Dental will process claims that you submit, will issue Explanation of Benefits (EOB's) and will determine when you have met your deductible.

- HSA distributions are tax-free if used for any of the qualified medical expenses of the participant, his or her spouse or dependents. This is true whether or not the spouse or dependent is covered by an HDHP.

- Money taken from an HSA that is used for non-qualified purposes is subject to ordinary income tax and is subject to an additional 20% penalty. (Once the account owner reaches age 65, distributions may be used for other purposes without being subject to the 20% penalty. However, funds used for non-qualified expenses will be subject to ordinary income taxes.)

- Eligible individuals age 55 or older may make additional "catch up" contributions. The catch up contribution for 2016 is $1,000.

- While you can use funds in the HSA to pay for any qualified medical expenses, only eligible expenses as defined by Guardian will count towards the calendar year deductible. For example, if you purchase a $100 pair of eyeglasses you may decide to use your HSA to pay for the glasses. However, the $100 you spent will not go toward satisfying the calendar year deductible under the medical plan.

- Since the High Deductible Health Plan uses a preferred provider network, you will still want show your ID card and have your provider file the claim before paying for your service. You will receive an explanation of benefits (EOB) that will list the discounted amount and your portion of the bill. Once the EOB is received, you can use your debit card, check, or on-line bill payment from your HSA to pay the providers charge.

- There is no time limit for claiming a reimbursement from your HSA account as long as you *incurred* the expense you are claiming *while covered* by a qualified HDHP and *after* the HSA was established.

- The HSA provider will send you a periodic statement detailing contributions from you and ELC and investment earnings and/or fees your account may have been charged. You may also be able to access this information on-line.

- Your HSA provider will report any HSA distributions to both you and the IRS on Form 1099-SA. Your HSA contributions will be reported to you on Form 5498-SA. These amounts should agree with what you report on your Form 1040 or 1040-EZ.

- The government allows you to increase or decrease your contributions throughout the year up until tax day (April 15th of the following year) and still receive the tax benefits.

- If you change from employee only to family coverage during the year (due to marriage or birth of a child), your allowable HSA contribution will change on the first day of the month in which you become covered by family coverage. The same holds true if you change from family to employee only coverage.

- Don't forget to keep all of your receipts and EOB's!

Note: Always check with your personal tax advisor for specific individual questions and advice.

Elizabeth Layton Center, Inc.
403(b) Plan Election Information
2018 Open Enrollment

Elizabeth Layton Center, Inc. participates in a 403(b) Retirement Plan, managed by a qualified plan administrator per Federal Law. Conditions and terms for withdrawal are subject to applicable Federal and State laws.

Elizabeth Layton Center, Inc. offers a 403(b) retirement plan to all of its employees, including part time employees. Employees may elect to make contributions to 403(b) retirement plan under a salary reduction agreement. Salary reduction limits are subject to IRS guidelines. Elective contributions to the plan by any employee are contributed on a pretax basis. The employee has full control over the investment of funds in the retirement account.

Elizabeth Layton Center, Inc. will offer employer matching contributions to the 403(B) retirement plan, beginning with first pay period after January 1st, 2018. Elizabeth Layton Center, Inc. will offer matching contributions to 403(b) retirement plan for full time employees (36+ hours worked per week) that have completed one year of employment.

1) For eligible employee contributions up to 4% of wages, employer (ELC) will match 50% of employee contributions
2) Examples:
    a. Employee Contribution 1 % of wages =ELC matching contribution .5 of wages
    b. Employee Contribution 2 % of wages =ELC matching contribution 1% of wages
    c. Employee Contribution 3% of wages =ELC matching contribution 1.5% of wages
    d. Employee Contribution 4 % of wages =ELC matching contribution 2% of wages
    e. Employee Contribution 5 % of wages =ELC matching contribution 2% of wages
    f. Employee Contribution 10% of wages =ELC matching contribution 2% of wages

Some basic rules related to your retirement plan contribution election:

1) Must use a percentage of wage contribution (fixed amount no longer allowed as of January 1, 2017)
2) All ELC employees are eligible to contribute to the retirement plan, regardless of Part or Full time status. ELC will provide matching contributions to Full Time employees only as indicated above.
3) We are requesting that **all** employees make an election to contribute or not contribute to the plan. The election form is attached.
4) You may elect to increase, decrease or discontinue your contribution to the plan at any point during the calendar year.

(If there are any errors in the statement of these eligibility rules the plan documents control dictate plan rules, not this summary of understanding of the plan rules.)

If you know what you want to elect, please fill out the attached "Designation of Salary Reduction" form and turn it in. Please be sure you fill in the election effective date. If your form is turned in with an election but no effective date, we will assume you are electing January 1, 2018, meaning the deduction will come out of your January 5, 2018 paycheck. If you wish to make any changes in your elections of fund investments within the plan, or if you are making a new election, you will need to contact Robbin Kerth at Peoples Bank, Ottawa, KS, phone 785-242-2900 to choose your investments and set up your individual 403(b) plan account.

ELIZABETH LAYTON CENTER
For Hope and Guidance

Serving Franklin County: 785.242.3780
Serving Miami County: 913.557.9096

TTY/TDD KS Relay 1.800.766.3777

Leslie Bjork, PsyD, LP
Executive Director

Donna Dornes
President, Board of Trustees

Gerald Gambrill, MD
Medical Director

Elizabeth Layton Center, Inc. 403(b) Plan

To help you prepare for retirement, Elizabeth Layton Center, Inc. offers you a 403(b) plan. You can choose to invest the contributions made to your account in a number of investment options. This notice describes the investment that will be used for contributions allocated to your account in the event you fail to select an investment option.

Investing in the plan

Unless you make an investment selection, your contributions will be invested in the default option for the Plan.
The default option for our Plan is the American Funds Target Date Retirement Series. Designed to simplify your investment decision-making, the Series is made up of 11 target date fund portfolios, each composed of a different mix of the American Funds, with retirement dates ranging from 2010 through 2060 in five-year increments. Each target date fund serves as a single diversified retirement portfolio — with an underlying investment approach aligned with its retirement date — so you only need to select one. Each fund in the Series attempts to balance investors' long-term needs for both return and conservation of capital.

American Funds investment professionals manage each target date fund's portfolio, moving it from a more growth-oriented strategy to a more income-oriented focus as the fund gets closer to its target date. American Funds investment professionals continue to manage the fund for 30 years after it reaches its target date. The target date is the year in which an investor is assumed to retire and begin taking withdrawals.

Although the target date funds are managed for investors on a projected retirement date time frame, the fund's allocation strategy does not guarantee that investors' retirement goals will be met. For investors who are close to, or in, retirement, each fund's equity exposure may result in investment volatility that could reduce an investor's available retirement assets at a time when the investor has a need to withdraw funds. For investors who are further from retirement, there is a risk that a fund's allocation may over-emphasize investments designed to preserve capital and provide current income, which may prevent the investor from reaching his or her retirement goals. For quarterly updates of the underlying fund allocations, visit **myretirement.americanfunds.com.**

In applying any particular asset allocation model to your own individual situation, you should also take into account your risk tolerance as well as your other assets and any investments outside your plan, such as your home equity, IRAs and savings accounts.

To determine which fund might be appropriate for you, find the date-specific fund in the following table that most closely matches the year in which you expect to retire and possibly start withdrawing money. If you fail to make an investment selection, your account contributions will be invested automatically in the fund whose target retirement date most closely matches your anticipated retirement at age 65.

Name of fund	Year of 65th birthday
American Funds 2060 Target Date Retirement Fund®	2058 and later
American Funds 2055 Target Date Retirement Fund®	2053 thru 2057
American Funds 2050 Target Date Retirement Fund®	2048 thru 2052
American Funds 2045 Target Date Retirement Fund®	2043 thru 2047
American Funds 2040 Target Date Retirement Fund®	2038 thru 2042
American Funds 2035 Target Date Retirement Fund®	2033 thru 2037
American Funds 2030 Target Date Retirement Fund®	2028 thru 2032
American Funds 2025 Target Date Retirement Fund®	2023 thru 2027
American Funds 2020 Target Date Retirement Fund®	2018 thru 2022
American Funds 2015 Target Date Retirement Fund®	2013 thru 2017
American Funds 2010 Target Date Retirement Fund®	2012 and earlier

For example, if the year of your 65th birthday is 2026, your account will be invested in the 2025 Fund; if the year of your 65th birthday is 2039, in the 2040 Fund; and if the year of your 65th birthday is 2051, in the 2050 Fund.

The 2060 Fund was added to the Series effective March 27, 2015. As a result, please be aware that if you were added to the Plan's recordkeeping system on or after March 27, 2015 and your retirement date is aligned with the 2058-and-later date range, you will be defaulted into the 2060 Fund. However, if you were added to the Plan's recordkeeping system prior to March 27, 2015 and your retirement date is aligned with the 2058-and-later date range, you will be defaulted into the 2055 Fund regardless of when you begin contributing to the Plan. See your quarterly statement to determine which fund you are currently invested in.

The target date funds are subject to the risks and returns of the underlying American Funds, which may be added or removed during the year. Investing outside the United States involves risks such as currency fluctuations, periods of illiquidity and price volatility, as more fully described in the funds' prospectuses. These risks may be heightened in connection with investments in developing countries. Small-company stocks entail additional risks, and they can fluctuate in price more than larger company stocks. Lower rated bonds are subject to greater fluctuations in value and risk of loss of income and principal than are higher rated bonds.

The return of principal in bond funds and funds with underlying bond holdings is not guaranteed. Fund shares are subject to the same interest rate, inflation and credit risks associated with the underlying bond holdings. While not directly correlated to changes in interest rates, the values of inflation-linked bonds generally fluctuate in response to changes in real interest rates and may experience greater losses than other debt securities with similar durations. Investments in mortgage-related securities involve additional risks, such as prepayment risk, as more fully described in the fund's prospectus. Investments in securities issued by U.S. governmental agencies or instrumentalities may not be guaranteed by the U.S. government.

Investments are not FDIC-insured, nor are they deposits of or guaranteed by a bank or any other entity, so they may lose value.

Investors should carefully consider investment objectives, risks, charges and expenses. This and other important information is contained in the funds' prospectus and summary prospectus, which can be obtained from a financial professional and should be read carefully before investing.

What if I do not want my contributions invested in the default fund?

To avoid having your contributions initially invested in the default fund, take the following action.

- Use your PIN to access your account either by visiting the Plan's website at **myretirement.americanfunds.com** or by calling the toll-free number at **(800) 204-3731**. Make your investment selection.

You can change the way your future contributions are invested at any time or you can make an exchange from the default investment into any other investment available for our plan by going to the website **myretirement.americanfunds.com** or calling the toll-free number, **(800) 204-3731**. There is no transaction fee for making an exchange into one of the other investment options available in our plan.

For more information, contact Robbin Kerth at 785-242-2900 or log on to **myretirement.americanfunds.com**.

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Pay Period Summary January 2018-January 2019

PAY DAY	PAY PERIOD	EMPLOYEE TIME SHEETS DUE TO SUPERVISOR BY 5PM	SUPERVISORS' EMPLOYEE TIME SHEETS DUE TO HR BY NOON
January 5, 2018	12/16/17-12/29/17	**Friday, December 29, 2017**	**Friday, December 29, 2017**
January 19, 2018	12/30/17-01/12/18	Friday, January 12, 2018	Monday, January 15, 2018
February 2, 2018	01/13/18-01/26/18	Friday, January 26, 2018	Monday, January 29, 2018
February 16, 2018	01/27/18-02/09/18	Friday, February 9, 2018	Monday, February 12, 2018
March 2, 2018	02/10/18-02/23/18	Friday, February 23, 2018	Monday, February 26, 2018
March 16, 2018	02/24/18-03/09/18	Friday, March 9, 2018	Monday, March 12, 2018
March 30, 2018	03/10/18-03/23/18	Friday, March 23, 2018	Monday, March 26, 2018
April 13, 2018	03/24/18-04/06/18	Friday, April 6, 2018	Monday, April 9, 2018
April 27, 2018	04/07/18-04/20/18	Friday, April 20, 2018	Monday, April 23, 2018
May 11, 2018	04/21/18-05/04/18	Friday, May 4, 2018	Monday, May 7, 2018
May 25, 2018	05/05/18-05/18/18	Friday, May 18, 2018	Monday, May 21, 2018
June 8, 2018	05/19/18-06/01/18	Friday, June 1, 2018	Monday, June 4, 2018
June 22, 2018	06/02/18-06/15/18	Friday, June 15, 2018	Monday, June 18, 2018
July 6, 2018	06/16/18-06/29/18	**Friday, June 29, 2018**	**Monday, July 2, 2018**
July 20, 2018	06/30/18-07/13/18	Friday, July 13, 2018	Monday, July 16, 2018
August 3, 2018	07/14/18-07/27/18	Friday, July 27, 2018	Monday, July 30, 2018
August 17, 2018	07/28/18-08/10/18	Friday, August 10, 2018	Monday, August 13, 2018
August 31, 2018	08/11/18-08/24/18	Friday, August 24, 2018	Monday, August 27, 2018
September 14, 2018	08/25/18-09/07/18	Friday, September 7, 2018	Monday, September 10, 2018
September 28, 2018	09/08/18-09/21/18	Friday, September 21, 2018	Monday, September 24, 2018
October 12, 2018	09/22/18-10/05/18	Friday, October 5, 2018	Monday, October 8, 2018
October 26,2018	10/06/18-10/19/18	Friday, October 19, 2018	Monday, October 22, 2018
November 9, 2018	10/20/18-11/02/18	Friday, November 2, 2018	Monday, November 5, 2018
November 23, 2018	11/03/18-11/16/18	Friday, November 16, 2018	**Monday, November 19, 2018**
December 7, 2018	11/17/18-11/30/18	Friday, November 30, 2018	Monday, December 3, 2018
December 21, 2018	12/01/18-12/14/18	Friday, December 14, 2018	Monday, December 17, 2018
January 4, 2019	12/15/18-12/28/18	**Friday, December 28, 2018**	**Monday, December 31, 2018**
January 18, 2019	12/29/18-01/11/19	Friday, January 11, 2019	Monday, January 14, 2018

DATES HIGHLIGHTED HAVE BEEN CHANGED DUE TO HOLIDAYS.

Working through President's Day February 19, 2018 will receive 8 hours of PTO toward bank for floating holiday on 03/02/2018 pay date.

EMPLOYEES: Time sheets will need to be turned in as soon as possible on June 29, 2018 before 4th of July Holiday and December 28, 2018 before New Year's Day Holiday.

Supervisors: Employee time sheets will need to be turned in on Friday at 5pm on June 29, 2018 and December 28, 2018. Timesheets will need to be turned in on Monday at 10 am on November 19, 2018 before Thanksgiving Holiday.

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HOLIDAYS FOR 2018

New Year's Day	Monday, January 1, 2018	Closed
Presidents' Day	(Each full-time employee will be given an additional 8-hours of PTO time in February to be used whenever they choose with approval from supervisor.)	
Memorial Day	Monday, May 28, 2018	Closed
Independence Day	Wednesday, July 4, 2018	Closed
Labor Day	Monday, September 3, 2018	Closed
Day Before Thanksgiving	Wednesday, November 21, 2018	Close at 5:00 p.m.
Thanksgiving Day	Thursday, November 22, 2018	Closed
Day After Thanksgiving (Taken in observance of Veteran's Day)	Friday, November 23, 2018	Closed
Christmas Day	Tuesday, December 25, 2018	Closed
New Year's Day	Tuesday, January 1, 2019	Closed