NORTH CENTRAL
MISSOURI MENTAL HEALTH CENTER

Employee Benefits Overview

www.ncmmhcbenefits.info

Your Bukaty Service Team

Your dedicated service team is available to help address claims, billing, and other benefit-related questions. Please contact them by phone, email, or fax. They will work to ensure your satisfaction.

Meet the Team

Brad Bukaty
Benefits Consultant
bbukaty@bukaty.com
913.647.3945

Brad oversees all aspects of your employee benefits program.

Lacy Albright
Client Service Specialist
lalbright@bukaty.com
913.777.5053

Lacy works in tandem with the carriers to ensure the best possible service for clients.

Carmen Weber
Account Manager
cweber@bukaty.com
913.222.5225

Carmen is responsible for the daily administrative and service issues including claims, billing, identification card request, and enrollments.

Matt Miller
VP Enrollment Services
mmiller@bukaty.com
913.653.8754

Matt is responsible for the enrolling and servicing of the group's worksite benefits.

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.

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.

Premium Only Plan
I agree that all group health benefits I enroll in will automatically be ran through a Premium Only Plan and that my salary will be reduced by the amount I pay for group health benefits. I understand this may reduce my potential Social Security benefits. I realize I can change this election only during the election period prior to any plan year or if there has been a qualifying change in my family's status, employment, or group health care coverage.

IMPORTANT INFORMATION, RIGHTS & DISCLOSURES

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage under our Employee Benefits Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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.
>
> We have determined that the prescription drug coverage offered under our medical benefit plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage may be affected. You should check with the carriers/vendors prior to joining a plan. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
You should contact Human Resources for additional plan information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

IMPORTANT INFORMATION, RIGHTS & DISCLOSURES

Newborns' and Mother's Health Protection Act
Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mothers' or newborns' length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 or 96 hours, as appropriate. However, Federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 hours for normal delivery or 96 hours for a cesarean delivery.

Mental Health Parity and Addiction Equity Act
The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Genetic Information Nondiscrimination Act
The Genetic Information Nondiscrimination Act of 2008 (GINA) which protects employees against discrimination based on their genetic information.

Plan Overview Guide
This Plan Overview Guide is intended for all employees, as well as their spouses and dependents that are benefits-eligible employees. This guide summarizes the plans that are available to the benefits-eligible employees and their eligible dependents. Official plan documents, policies, and certificates of coverage contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your plan. If there is any conflict, the official documents prevail. Information provided in this guide is not a guarantee of benefits. These documents are available upon request through Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Annual Notice
Your employer, in accordance with HIPAA, protects your Protected Health Information (PHI). Your employer will only discuss your PHI with providers and third-party administrators when necessary to administer the plan that provides your benefits or as mandated by law. This Employee Benefits Plan is compliant with all aspects of the Patient Protection and Affordable Care Act (the Affordable Care Act).

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.

IMPORTANT INFORMATION, RIGHTS & DISCLOSURES

New Health Insurance Marketplace
Coverage Options and your Health Coverage

PART A: General Information

The Health Insurance Marketplace is a way to buy health insurance. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The Open Enrollment period for 2021 coverage is November 1, 2020 to December 15, 2020. If you haven't enrolled in coverage by then, you generally can't buy Marketplace coverage until the next Open Enrollment period for coverage the following year.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. *

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Plan Administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered By Your Employer

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

1.	N/A	7.	Trenton
2.	43-1029409	8.	Missouri
3.	North Central Missouri Mental Health Center	9.	64683
4.	1601 E 28th Street Trenton, MO 64683	10.	Cara Farmer
5.	(660) 359-4487	11.	N/A
		12.	cara@ncmmh.com

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

- As your employer, we offer a health plan to employees who are regularly scheduled to work 30+ hours per week.
- With respect to dependents: We do offer coverage for eligible dependents. Eligible dependents are: Your legal spouse and/or dependent child(ren) under age 26.
- We believe our coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums

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* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Medical: Blue Cross KC

Blue Cross KC

You are eligible to participate in the medical benefits plan on the first of the month following 60 days. Eligible dependents may also participate; eligible dependents include your legal spouse and/or dependent child(ren) to age 26. Below is overview, but detailed Summary of Benefits & Coverage is listed on last four pages of this booklet.

The following tables will give you an overview of how the plans work and what your responsibilities are. For questions concerning your medical benefits, a claim, to identify a network provider, or if you have questions concerning your prescription drug coverage please contact Brad Bukaty at 913-647-3945, bbukaty@bukaty.com or visit www.bluekc.com.

Network		
Deductible Individual/Family (per calendar year)	$500/$1000	
Out-of-Pocket Max per Family Member (deductible & all copays apply) Individual/Family (per calendar year)	$1500/$3000	
Coinsurance:Amount Blue Cross covers after Deductible is met	90%	
Preventive and Routine Care	$0, Covered in Full	
Office visit (PCP/Specialist)	$20	
X-ray and Lab Services (Diagnostic)	EE pays in full, appiled to Ded, pay 10%	
Allergy Injections	EE pays in full, applied to Ded, pay 10%	
Retail Pharmacy Drug Coverage Tier 1/ Tier 2/ Tier 3/ Tier 4	$15/$70/$110/$200	
Inpatient Hospital Care	EE pays in full, applied to Ded, pay 10%	
Outpatient Hospital Care	EE pays in full, applied to Ded, pay 10%	
Urgent Care	$20	
Emergency Room (copay waived if admitted)	EE pays in full, applied to Ded, pay 10%	
Durable Medical Equipment	EE pays in full, applied to Ded, pay 10%	
Physical therapy, occupational therapy (see Medical Plan Summary for max # visits)	$20	
Outpatient Mental Health/Substance abuse office visit	$20	
Annual Maximum	Unlimited	

DELTA DENTAL

BENEFITS OVERVIEW

Proposal For: North Central Missouri Mental Health
Effective Date: Care 8/1/2023

Delta Dental PPO -*DentaFlex*		Delta Dental PPO℠	Delta Dental Premier®	Out-of-Network Providers
Calendar Year Deductible	• Applied to Basic and Major services	$50 individual 3X family	$50 individual 3X family	$50 individual 3X family
Annual Maximum	• Applied to Preventive, Basic and Major services	$1,500	$1,500	$1,500
Preventive Services	• Bitewing x-rays, one set per benefit period • Emergency palliative treatment • Full-mouth x-rays (pano), once in any 36 month period • Oral examinations, twice in any benefit period • Periapical x-rays, as required • Periodontal Maintenance, twice in any benefit period (subject to your prophylaxis frequency limitation) • Prophylaxis (cleanings), twice in any benefit period • Sealants for dependent children under age 16, once in 5 years • Space Maintainers for dependent children under age 16, once in 5 years • Topical fluoride treatments for dependent children under age 16, once in any benefit period	100%	100%	80%
Basic Services	• Composite fillings • Endodontics • Fillings • Non-Surgical Periodontics • Oral Surgery (excluding extractions) • Simple Extractions • Surgical Extractions • Surgical Periodontics	90%	90%	60%
Major Services	• Bridges, once in 7 years • Crowns, Inlays, Onlays, once in 7 years • Dentures, once in 7 years • General Anesthesia	60%	60%	40%
Orthodontia	• Not covered	N/A	N/A	N/A
MAX*Advantage*	Charges for preventive exams, cleanings, and x-rays will not be applied to the annual benefit maximum.			

About Delta Dental networks

Delta Dental PPO Providers: agree to accept contractual reimbursement as payment in full and will not balance bill.

Delta Dental Premier Providers: agree to accept contractual reimbursement as payment in full and will not balance bill.

Out-of-Network Providers: are not contracted with Delta Dental and therefore may balance bill the difference between Delta Dental's out-of-network payment and billed charges.

Delta Dental PPO Providers typically offer the greatest discounts.

Monthly Rates

Coverage Tier	Rates
Employee	$24.84
Employee & Spouse	$50.81
Employee & Child(ren)	$50.42
Family	$81.01

DeltaVision®

DELTA DENTAL®

DYNAMIC SELECT PLUS 150 ALLOWANCE PLAN

EMPLOYER GROUP: North Central Missouri Mental Health Care

EFFECTIVE DATE: August 1, 2023

QUOTE DATE:

COPAYS[1]	Exam	$10
	Materials	$25

FREQUENCY	Eye Exam	Every 12 Months
	Eyeglass Lenses	Every 12 Months
	Eyeglass Frames	Every 24 Months
	Contact Lenses	Every 12 Months

All Frequencies run on a Calendar Year basis.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK[2]
EXAMS		
Comprehensive Eye Examination *(with dilation)*	Covered in full after copay	Reimbursed up to $40
Contact Lens Fit & Follow-up	$40 allowance (copay does not apply)	Not covered
MATERIALS		
Eyeglasses[3] *(in lieu of contact lenses)*		
Standard Plastic CR-39 Lenses ▪ Single ▪ Bi-focal ▪ Tri-focal ▪ Lenticular	Covered in full after copay	Reimbursed up to: ▪ Single: $20 ▪ Bi-focal: $40 ▪ Tri-focal: $60 ▪ Lenticular: $100
Polycarbonate Lenses *(members age 19 and under)*	Covered in full (copay does not apply)	Not covered
Standard Progressive Lenses	Additional $50 copay	Not covered
Photochromic Lenses	Additional $60 copay	Not covered
Standard Frames	$150 retail allowance	Reimbursed up to $60
Contact Lenses[4] *(in lieu of eyeglass lenses and frames)*		
Elective Contact Lenses	$150 retail allowance	Reimbursed up to $90
Medically Necessary Contact Lenses[5]	$250 retail allowance	Reimbursed up to $250

1. Copays apply to all benefits except where noted. 2. For out-of-network benefits, member is reimbursed up to the amount shown less copay. 3. Single materials copay applies with standard lenses and frames when purchased together. 4. Benefit paid only once during the group's benefit period; must be fully utilized at the time of purchase. 5. Medically Necessary Contact Lenses limited to conditions of aphakia, keratoconus, or severe anisometropia.

DELTAVISION *VALUE* DISCOUNTS

Covered members can take advantage of discounted services and materials at participating discount provider locations.

Polycarbonate Lenses[1] (Members over age 19): $40
Frames: 20% off amount over allowance
Laser Vision Correction: Member discounts up to 50%.

[1]Only applies to single vision lenses.
The discount features are not insurance and may be subject to change without notice. Not all providers participate in DeltaVision Value Discounts. Call your provider or visit our website to confirm if they offer discounts.

RATE GUARANTEE 24 Months

MONTHLY PREMIUMS		Monthly Premiums *With Dental Bundle*
Single		$4.85
Employee & Spouse		$9.09
Employee & Child(ren)		$10.31
Family		$15.03

Rates quoted are based on dependent coverage up to age 26.

NCMMHC VOLUNTARY LIFE INSURANCE

This Voluntary, Employee Paid Life Insurance is in addition to the $50,000 of Life Coverage already provided by NCMMHC:

No Medical Questions for Employee Coverage up to $150,000 when first eligible.

No Medical Questions on Spouse Coverage up to $30,000 when first eligible.

No Medical Questions on Child Coverage Up to $10,000 when first eligible.

If Spouse coverage is elected, employee must enroll in at least double such coverage

For example, if $30,000 coverage is elected for Spouse, then at least $60,000 must be elected for Employee

Same guideline applies for Child coverage.

Spouse premium is guided by Employee age.

Principal requires minimum 20% enroll at inception.

Each yearly renewal, EE can increase by $20K w/no medical questions, & spouse by $10K.

FLEXIBLE SPENDING ACCOUNT
HEALTH CARE FSA

How does a Health Care FSA work?

A health care Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for eligible medical, dental, and vision expenses for you and your dependents – even if they're not covered under your primary health plan.

You choose an annual election **up to $2,750**
At the beginning of the plan year, your account is pre-funded and your full contribution is immediately available. Your contribution is then deducted from your paychecks in equal amounts throughout the year.

Why should I enroll in a Health Care FSA?

Almost everyone has some level of predictable and nonreimbursable medical needs. If you expect to incur medical expenses that won't be reimbursed by another plan, you'll want to take advantage of the savings an FSA offers.

Money contributed to a health care FSA is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving on health care expenses in addition to bringing home more money!

Mobile and online access

NueSynergy makes it easy to access and manage your health care FSA information.

- **NueSynergy smart mobile app:** Our smart mobile app provides real-time, secure benefit account access anywhere at any time. You can even shop for providers and pharmacies based on cost, quality and location.
- **NueSynergy member portal:** Log in to our website, www.NueSynergy.com, as a member and you'll have a wide variety of tools and resources available to you.

How do I use my Health Care FSA to pay for eligible expenses?

You can use the NueSynergy smart debit card we'll provide to pay for eligible health care expenses. Or you can pay with your personal funds and submit a claim for reimbursement.

Simple to use and easy to save

A health care FSA is easy to use and simple to understand. Here are some helpful hints to know before you take advantage of your tax savings:

- Your full election amount is available on the first day of the plan year, which means you'll have access to the money you need, when you need it.
- Save your receipts when you spend your health care FSA dollars. You may need itemized invoices to verify the eligibility of expenses or for reimbursement requests.
- The easiest way to manage your account is online at www.NueSynergy.com or through the NueSynergy smart mobile app.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event (like a marriage, divorce, etc.).
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your health care FSA by the end of the plan year.
- You may carry over up to $550 of unused health care FSA dollars to the next plan year, allowing you to enjoy tax savings without risk.

&

Convenient & Controlled.
Easy to use and easy to budget.

Annual tax-free contribution of up to $2,750 in 2021.

Have questions or need more information? Call 855-890-7239.

NueSynergy
CUSTOMER FOCUSED & TECHNOLOGY DRIVEN

Full-service administration of consumer-driven and traditional account-based plans.
855.890.7239 • 4601 College Blvd. Suite 280, Leawood, KS 66211 • www.NueSynergy.com

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Example of qualifying expenses

Your health care FSA can cover costs for hundreds of eligible medical, dental, and vision expenses for you and your dependents, such as:

- Feminine care products
- Over the counter medications
- Copays, deductible payments, coinsurance
- Doctor office visits, exams, lab work, x-rays
- Hospital charges
- Prescription drugs
- Dental exams, x-rays, fillings, crowns
- Orthodontia, including braces
- Vision exams, frames, contact lenses, contact lens solution
- Laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies and first aid kits

Example of non-qualifying expenses

There are certain expenses that are not eligible for reimbursement from your health care FSA, such as:

- Expenses incurred in a prior plan year
- Cosmetic procedures or surgery
- Insurance premiums
- Deodorant
- Fitness programs
- Teeth whitening
- Hair transplants
- Exercise equipment
- Concierge service fees
- Late payment fees charged by health care providers

More information about eligible expenses

A comprehensive list of eligible expenses can be found at www.NueSynergy.com.

Here's an example

With a $35,000 salary, an individual electing the health care FSA and contributing $2,750 for the plan year **can save $619**.

	HEALTH CARE FSA	EXPENSES	NOT PARTICIPATING	
	$35,000	INCOME BEFORE TAX	$35,000	
Elects to contribute $2,750	$2,750	FSA CONTRIBUTION	$0	No contribution
Only taxed on $32,250	$32,250	TAXABLE INCOME	$35,000	Taxed on full $35,000
	$7,256	TAXES (FEDERAL, STATE, FICA)	$7,875	
No out-of-pocket expense	$0	OUT-OF-POCKET HEALTH CARE EXPENSE	$2,750	Ends up spending $2,750
Income is **$619 more** with an FSA	**$24,994**	INCOME AFTER TAX	**$24,375**	Income is **$619 less** than with an FSA

Total Savings: $619 a year

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Health Benefit Plan Summary - PCB PPO $500 (OOPM $1500) MO

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, exclusions and limitations refer to your member certificate available at MyBlueKC.com.

General Plan Information		
Plan Type	**Preferred Provider Organization (PPO)** Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com.	**In Area:** Preferred-Care Blue **Out-of-Area:** BlueCard PPO/EPO	
Deductible – Embedded You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	**In-Network** Individual: $500 Family: $1,000	**Out-of-Network** Individual: $500 Family: $1,000
Coinsurance The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.	**In-Network** Member Pays: 10% Plan Pays: 90%	**Out-of-Network** Member Pays: 30% Plan Pays: 70%
Out-of-Pocket Limits – Embedded The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services. These cost shares apply to the Out-of-Pocket Limit: Coinsurance, Deductibles, Copays **Applies to:** All Medical and Rx Cost Sharing	**In-Network** Individual: $1,500 Family: $3,000	**Out-of-Network** Individual: $3,000 Family: $6,000
Dependent Limiting Age	26	
Customer Service	**PH:** 816-395-3558 (local) or 1-888-989-8842 (toll free)	

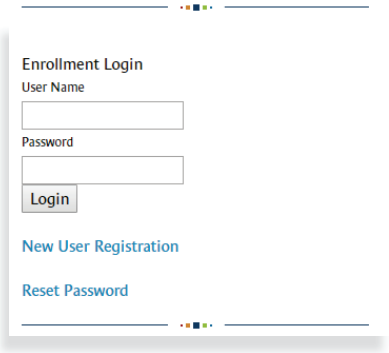
Plan Benefits - Medical		
When you visit a health care provider's office or clinic…	**In-Network**	**Out-of-Network**
Physician ***Primary Care Physician (PCP)*** - An internist, family practitioner, general practitioner, or pediatrician.	$20 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	$20 Copay/Visit, no Deductible	30% Coinsurance after Deductible

Other Services & Procedures performed in a provider's office and not included with an office visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Center	$20 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$10 Copay/Visit, no Deductible	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s). All other virtual care services subject to applicable cost sharing.	$10 Copay/Visit, no Deductible	Not applicable
Preventive Screenings & Immunizations (Children & Adults) Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Services must be billed with a primary diagnosis of preventive to be covered at 100%. Refer to your member certificate for additional details.	No member cost share	30% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	30% Coinsurance after Deductible
Allergy		
Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Treatment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you need radiology services…	**In-Network**	**Out-of-Network**
X-Ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
When you have out-patient surgery…	**In-Network**	**Out-of-Network**
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you need immediate medical attention…	**In-Network**	**Out-of-Network**
Urgent Care Center Office Visit	$20 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Emergency Services Copay Waived if Admitted Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	$100 Copay/Visit, then Deductible, then 10% Coinsurance	$100 Copay/Visit, then In-Network Deductible, then 10% Coinsurance
Ground Ambulance Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after In-Network Deductible
If you have a hospital stay…	**In-Network**	**Out-of-Network**

Hospital Facility Fees Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physician (Surgeon) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you need help recovering or have other special health needs…	**In-Network**	**Out-of-Network**
Skilled Nursing Care Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Hospice Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you have behavioral health, or substance abuse needs…	**In-Network**	**Out-of-Network**
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services **Office Visit**	$20 Copay/Visit, no Deductible	30% Coinsurance after Deductible
Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Family Planning & Pregnancy…	**In-Network**	**Out-of-Network**
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	30% Coinsurance after Deductible

Elective Sterilization – Women	No member cost share	30% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	30% Coinsurance after Deductible
Maternity Dependent daughters are covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: Not Covered	Not covered	Not covered
Routine Vision Care…	**In-Network**	**Out-of-Network**
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network Provided by Vision Service Plan (VSP)	$20 Copay/Visit, no Deductible	$20 Copay/Visit, no Deductible Limited to $45 Benefit Max per Calendar Year.
General Pharmacy Information		
Retail Pharmacy Network(s)	RxPremier	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	Premium Formulary	
Specialty Pharmacy A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions. Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	OptumRx Specialty Services **PH:** 1-855-427-4682	
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	**In-Network** Combined with Medical Out-of-Pocket Limits	**Out-of-Network** Combined with Medical Out-of-Pocket Limits
Plan Benefits – Pharmacy		
When you use a retail or specialty pharmacy...	**In-Network**	**Out-of-Network**
Retail Pharmacy (Short-term supply: Up to 34 Days**)**		
Drug Tier 1: Generic / Generic Specialty	**RxPremier:** $15 Copay/Fill Contraceptives – No member cost share	$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	**RxPremier:** $70 Copay/Fill	$70 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred / Preferred Specialty	**RxPremier:** $110 Copay/Fill	$110 Copay/Fill, then 50% Coinsurance
Drug Tier 4: Non-Preferred Specialty	**RxPremier:** $200 Copay/Fill	$200 Copay/Fill, then 50% Coinsurance
When you use a mail order pharmacy…	**In-Network**	**Out-of-Network**
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		
Drug Tier 1: Generic	$37.50 Copay/Fill Contraceptives – No member cost share	$37.50 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	$175 Copay/Fill	$175 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	$275 Copay/Fill	$275 Copay/Fill, then 50% Coinsurance

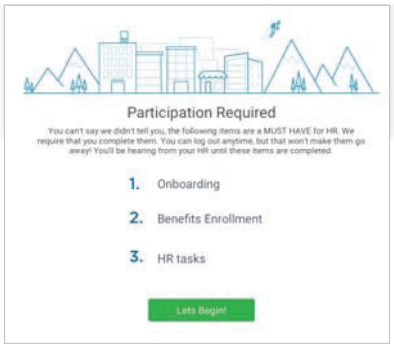
ENROLL IN YOUR BENEFITS: One step at a time



Step 1: Log In

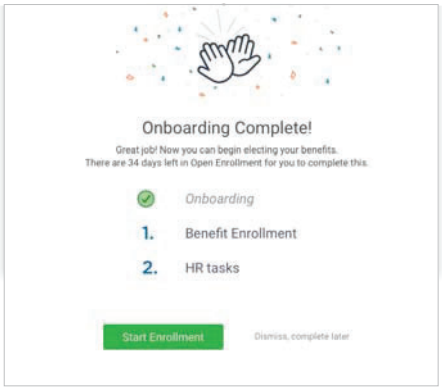
Go to www.bukaty.com/online–enrollment

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- You will be asked to provide the following:
  - First and last name
  - PIN (last four digits of your SSN) o DOB (MM/DD/YYYY)
  - Company Identifier: **North Central Missouri**



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

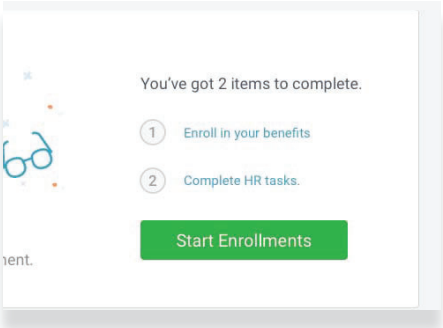


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

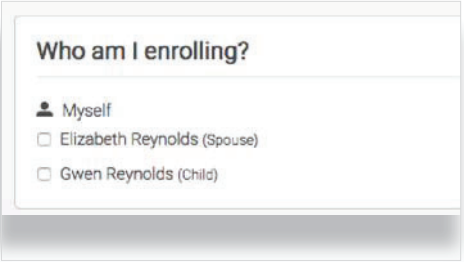
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

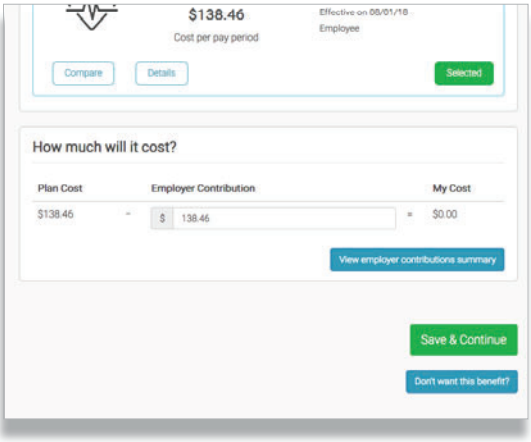
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

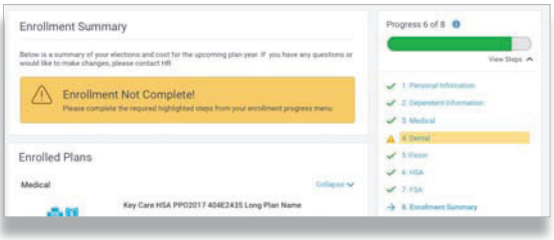


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

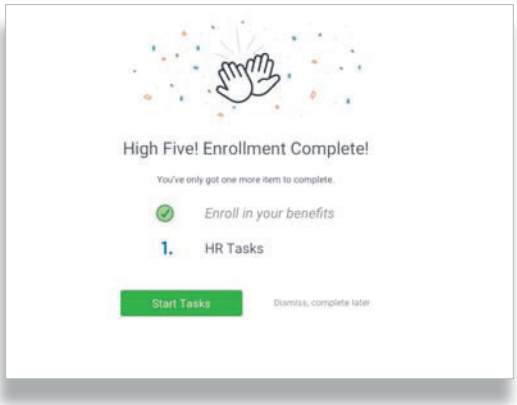


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7