2018 Benefits Guide for

Retirees

Plan Year Begins January 1, 2018

Kansas City Area Transportation Authority

Dear KCATA Associate:

Like clockwork, the onset of Fall ushers in open enrollment time! I am pleased to share with you that KCATA will again offer a valuable benefit package so that you can ensure health care for you and your family.

This booklet explains your benefits, which continue to be competitive with other employers in the area. Although medical premiums will increase in 2018, just as they have nationwide, your coverage will not be diminished. Dental rates will remain the same and Vision rates will actually be reduced. We will continue to offer Humana Go365 so that you have the opportunity to enjoy rewards for activities that promote a healthy lifestyle. In addition, KCATA will continue to invest in an on-site fitness center and annual biometric exams.

I hope you will take full advantage of the benefits that are available to you. I'm deeply grateful for the work you do every day to fulfill our mission of connecting people to opportunities.

Looking forward…

Robbie Makinen
President & CEO

Our employees are our most valuable asset.

That's why we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.

Stay Healthy

- Blue KC Medical
- Delta Dental of Missouri Dental
- VSP Vision

Feeling Secure

- The Hartford Group Term Life

Work/Life Balance

- Retiree and Dependent Bus Passes

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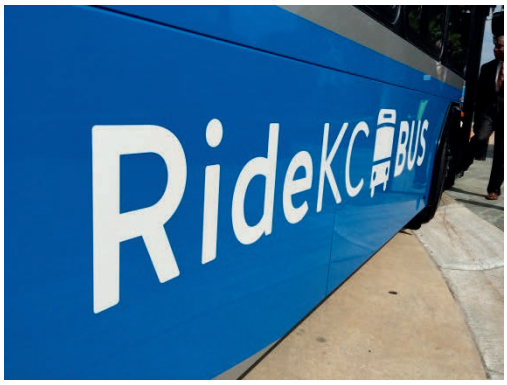
Contact Information

Online Enrollment (Available October 30 – November 10, 2017)
Explain My Benefits
321-296-8060 Option 1
www.explainmybenefits.com

Medical
Blue KC
816-395-3558
www.mybluekc.com

Dental
Delta Dental of Missouri
800-335-8266
www.deltadentalmo.com

Vision
VSP Vision Care
800-877-7195
www.vsp.com



Group Retiree Life Insurance
The Hartford
877-404-0422
www.thehartfordatwork.com

457 Plans
Voya
800-262-3862
816-221-4141 Contact: Grace Hintz
www.voya.com

ICMA-RC
800-669-7400
202-553-6578 Contact: Michael Howard
www.icmarc.org

Unresolved Questions

CBIZ

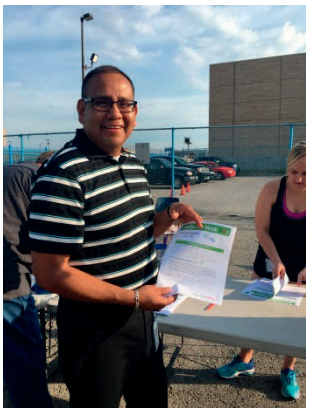
Michelle Conn
816-945-8224
mconn@cbiz.com

Susan Endicott
816-945-5289
sendicott@cbiz.com

CBIZ Benefits & Insurance Services is our dedicated benefits consultant.

All benefit plan documents are available by contacting the appropriate vendor.

Benefit Eligibility



Who is Eligible?

As a KCATA retiree, you and your eligible dependents are the only individuals that may receive the benefit of coverage under any KCATA benefit plan. Spouses and dependent children up to age 26 are eligible for coverage as well. This includes step-child, natural, legally adopted, disabled adult child (if disabled prior to age 22) and any court ordered dependent.

All KCATA retirees must have documentation of PROOF OF DEPENDENCY on file for coverage of their eligible dependents. If you are adding a spouse or other eligible dependent(s) to your benefit coverage, you must provide Human Resources/Work Life Division documentation of relationship and dependency, plus each dependent and spouse's Social Security number by November 15, 2017 before coverage becomes effective.

Examples of acceptable documentation to submit by category include:

- Spouse - marriage certificate/license.
- Children - birth certificate, confirmation of birth, adoption document, and/or court document
- Disabled Adult Child - If the child is over 26 years of age and the disability began before attaining age 22, documentation may be the disability certification letter issued by the Social Security Administration, or a statement from an attending physician.

  Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Providing false information and/or placing individuals who are not eligible dependents on your benefit plan is insurance fraud. Any retiree found to have furnished false information or provided ineligible individuals with KCATA benefits will be obligated to pay all claims and expenses incurred by all ineligibles, medical coverage will be rescinded and you may be subjected to legal action by the service provider.

Enrollment Process

How to Enroll

We have again partnered with Explain My Benefits, our benefit technology/communication vendor to assist in our Open Enrollment.

For more information about your Benefits and to Enroll please visit:

www.KCATA-retiree-benefits.com

You may call the Explain My Benefits Call Center at 321-296-8060, Option 1 to enroll over the phone or self-enroll online at www.KCATA-retiree-benefits.com.

How to Self-Enroll in Benefits via EMB Enroll

1. Access the Online Enrollment at: www.KCATA-retiree-benefits.com
2. Click the blue Enroll button under Options to Enroll
3. Please follow the instructions on the page and proceed to your enrollment
4. Complete your enrollment
5. IMPORTANT: RECORD YOUR CONFIRMATION NUMBER

   _____
6. If you have questions or need assistance with your enrollment, please call the Explain My Benefits Call Center at 321-296-8060, Option 1, between 8:00am – 4:00pm CST, Monday through Friday.

DEPENDENT INFORMATION

If you intend to elect ANY benefit for your spouse and/or eligible dependents, they must be listed as dependents in the system and you MUST have their SSN to input into the system. You will not be able to proceed with your enrollment and confirm your elections without inputting the SSN's for your spouse and/or dependents. Spouse, Children and Family coverage levels will not be available for you to select if the dependent information is not present on your record.

Some coverage offered will require additional forms to apply or increase coverage. It is your responsibility to ensure all appropriate forms are turned in to Human Resources/Work Life Division in a timely manner. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualifying event.

Current retirees can only enroll or change benefits during Annual Open Enrollment, unless there is a qualifying event. Please contact the Human Resources/Work Life Division if you experience a qualifying event.

When to Enroll

Retirees may enroll or change benefits during Open Enrollment, October 30 – November 10, 2017, for January 1, 2018 effective date.

The **last day** to enroll or make changes in benefits for 2018 will be November 10, 2017.

How to Make Changes after Open Enrollment – Qualifying Event

Unless you experience a qualified change in status you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

If you experience a qualifying change in status you must notify KCATA Human Resources/Work Life Division **within 30 days** of the change to modify your benefit selections, otherwise you will be able to make changes during the 2018 Open Enrollment period.

Be sure to print your 2018 Benefit Confirmation Statement and keep it for your records and future reference.

Disclaimer:

Understand that KCATA is not acting as an insurer or as an agent for any insurance provider, and has no liability for the manner in which your insurance coverage is selected, provided and managed. KCATA shall be held harmless from any and all liability for claims, disputes, or causes of action arising by reason of the selection, provision, or nature and extent of insurance coverage provided to any employee.

Benefit Overview

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Group Life Insurance
- Breen Fitness Center
- Retiree and Dependent Bus Passes

WHAT YOU SHOULD KNOW ABOUT YOUR 2018 KCATA BENEFITS

Retirees who do not make changes during Open Enrollment for 2018 will –

- Maintain the same medical coverage in 2018 as carried in 2017 excluding the medical reimbursement (MRO) which must be applied for annually.
- **It is highly recommended that you log into www.kcata-retiree-benefits.com and verify the accuracy of personal information and your beneficiary information.**

Medical Insurance

KCATA offers three medical plans through Blue KC.

- Rate Saver HMO (Blue Care HMO Network)
- Blue Care HMO (Blue Care HMO Network)
- PPO (Preferred-Care Blue Network)

BlueCross BlueShield of Kansas City

Retirees must choose a primary care physician (PCP) if you elect to enroll in the Rate Saver HMO or the Blue Care HMO plans. Treatment outside the HMO network **is not covered**, unless emergency services. However, the PPO plan allows you to receive services at any service provider and offers greater flexibility to seek treatment from providers both in and outside the network. Using providers outside the network usually results in greater out-of-pocket costs.

Blue KC Plans **Retiree** Costs

	Total Monthly Premium	KCATA Pays	Retiree Pays	Age 65 or When Medicare Eligible
Rate Saver				
Retiree Only	$ 752.48	$677.23	$ 75.25	$ 752.48
Retiree/Spouse	$1,580.42	$677.23	$ 903.19	$1,580.42
Retiree/Children	$1,430.14	$677.23	$ 752.91	$1,430.14
Family	$2,257.70	$677.23	$1,580.47	$2,257.70
Blue Care HMO				
Retiree Only	$ 886.72	$798.05	$ 88.67	$ 886.72
Retiree/Spouse	$1,862.34	$798.05	$1,064.29	$1,862.34
Retiree/Children	$1,685.24	$798.05	$ 887.19	$1,685.24
Family	$2,660.48	$798.05	$1,862.43	$2,660.48
Preferred Care Blue PPO				
Retiree Only	$ 937.22	$843.50	$ 93.72	$937.22
Retiree/Spouse	$1,971.14	$843.50	$1,127.64	$1,971.14
Retiree/Children	$1,783.56	$843.50	$ 940.06	$1,783.56
Family	$2,815.76	$843.50	$1,972.26	$2,815.76

You Can Move to Direct Deposit

As a retiree, you have the option to have your monthly pension payment directly deposited into your bank account on the first business day of each month. If you are currently receiving a check by mail and want the security of knowing your monthly payment is safely received and deposited, please request a Direct Deposit form from Human Resources/Work Life Division.

Blue KC Plans

	Ratesaver HMO	Blue Care HMO	Preferred-Care Blue
Plan Type	A Health Maintenance Organization (HMO) Blue Care HMO Network		A Preferred Provider Organization (PPO)
Plan Description	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; **other services must be ordered by an HMO Physician.**		Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	N/A	N/A	Network: $200 per individual/$400 per family; Non-network: $600 per individual/$1,200 per family
Coinsurance *(1)*	90% Coinsurance (applies only to inpatient services at a hospital and outpatient surgeries at a hospital or an outpatient facility)	N/A	Network: 90% / Non-network: 70%
Out-of-Pocket Maximum *(2)*	$2,000 individual/$4,000 family	N/A	Network: $1,000 individual/$2,000 family; Non-network: $2,000 individual/$4,000 family
Physician Office Visits	Medical Home PCP office visits: $10 copay *(3)* PCP office visits: $20 copay Specialists: $35 copay	Medical Home PCP office visits: $10 copay *(3)* PCP office visits: $20 copay Specialists: $35 copay	Network: Medical Home PCP $15 Copay* (office visit only) *(3)(6)* All Other Physicians $25 copay (office visit only) *(6)* Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab	No copay	No copay	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	No copay	No copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	No copay	No copay	Network: Deductible then coinsurance *(8)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	100%	100%	Network: 100% Related Office Visit: No copay Non-network: Deductible then coinsurance Unlimited Calendar year maximum
Mammograms, Pap Test and PSA tests	100%	100%	Network: No copay Non-network: Deductible then coinsurance
Routine Vision Care *(4)*	$20 copay	$20 copay	Network: $25 copay Non-network: Deductible then coinsurance One exam per year
Childhood Immunizations	100%	100%	Network: 100% Non-network: Deductible then coinsurance
Inpatient Hospital Services/ Outpatient Surgery *(5)*	90% Coinsurance	$100 copay per day up to $500 per calendar year	Deductible then coinsurance *(8)*

MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	$150 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	$150 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	Deductible then coinsurance *(5)*
Emergency Room/Urgent Care *(Copay waived if admitted to a hospital)*	$150 copay; $35 copay if services are received in an **urgent care center**.	$150 copay; $35 copay if services are received in an **urgent care center**.	ER: $150 copay then Deductible then 90% Urgent Care: Network: $25 Copay (office visit and lab only) *(9)* Non-network: Deductible then coinsurance
Ambulance	No copay Ground ambulance; No limit per use.		Deductible then 90%
Durable Medical Equipment *(5)*	No copay	No copay	Deductible then coinsurance
Allergy Testing, Treatment, Injections	No copay for injections; $100 copay for testing	No copay for injections; $100 copay for testing	Deductible then coinsurance
Home Health Services *(5)*	No copay 60 visit calendar year maximum	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Skilled Nursing Facility *(5)*	No copay 30 day calendar year maximum	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy *(Speech, Hearing, Physical and Occupational) (5)*	No copay Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	No copay Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: Combined 60 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services	No copay	No copay	Network: $25 copay (office visit only) (7) Non-network: Deductible then coinsurance
Inpatient Mental Illness/Substance Abuse *(5)*	90% Coinsurance	$100 copay per day up to $500 per calendar year	Deductible then coinsurance *(8)* Prior authorization required from New Directions
Outpatient Mental Illness/Substance Abuse *(5)*	Office Visit & Therapy: $10 copay	Office Visit & Therapy: $10 copay	Network Office Visit $15 Copay (office visit only) All Other Services Deductible then coinsurance *(8)* Non-network: Deductible then coinsurance
Organ Transplant *(5)*	Applicable copays Unlimited Organ Transplant lifetime maximum	Applicable copays Unlimited Organ Transplant lifetime maximum	Deductible then coinsurance Unlimited Organ Transplant lifetime maximum
Inpatient Hospice Facility *(5)*	90% up to $2,000/$4,000 Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	$50 copay per day up to $500 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum
Contraceptive devices, implants, injections and elective sterilization (includes insertion of devices)	Network: Covered at 100% Non-Network: Not Covered	Network: Covered at 100% Non-Network: Not Covered	Network: Covered at 100% Non-network: Deductible then 70%

Prescription Drugs *(5)*	**Blue KC RX Network:** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug	**Blue KC RX Network:** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug	**Blue KC RX Network** $12 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $30 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug Non-network: 50% after copay
Prescription Drugs: Express Scripts: Mail order drug program – 102 day supply	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 drug; $120 copay for Tier 3 brand drug	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 drug; $120 copay for Tier 3 brand drug	$24 copay for Tier 1 drug; Tier 1 generic contraceptives covered at 100% $60 copay for Tier 2 brand drug; $120 copay for Tier 3 brand drug
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Notice of Religious Rights	Your coverage does include elective pregnancy termination coverage. An enrollee who is a member of a group health plan with coverage for elective abortions as the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. Please call Customer Service to exclude coverage.		
Dependent Coverage Missouri Mandate: Dependent daughters covered for maternity on **Blue-Care**.	End of the year the children reach age 26		
Prior Authorization Penalty *(5)*	Prior authorization is the responsibility of the network provider.		You are responsible for prior authorization for services received. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.		
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.		
Customer Service	**816-395-3558 or *www.bluekc.com***		

[1] *Portion of covered charges paid by Blue KC after you satisfy your deductible and required copayments.*

[2] *Total of deductible and coinsurance members pay each year toward covered charges before Blue KC pays 100% of benefits.*

[3] *Medical Home PCP – Participating Medical Home physicians can be found in the Provider Directory with the Blue Distinction Total Care (BDTC) designation.*

[4] *Vision Care: You may receive one vision exam per year (PCP referral not required).*

[5] *Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hi-tech scans, speech and hearing therapy (including home health for speech therapy), prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.*

[6] *Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.*

[7] *Other services/procedures including skeletal manipulations performed in a chiropractor's office are subject to the Preferred Deductible and Coinsurance level.*

[8] *Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to a $200 calendar year maximum.*

[9] *Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.*

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

Medicare Part B Stipend Option (MRO)

Medicare Part B Eligible Retirees

Upon attainment of age 65 or becoming eligible for Medicare benefits, the Authority shall pay $21.50 for Medicare Part B. Retirees shall be required to apply for Medicare benefits when first eligible, regardless of age and show proof of their Medicare Card in order to receive the reimbursement. Retirees can only enroll for the Medicare Part B Stipend in Human Resources/Work Life Division.

Dental Insurance

This dental benefit option allows employees and their eligible covered dependents to see any dentist they choose. **To take advantage of the highest plan coverage and lowest out-of-pocket expenses, utilize a Delta Dental Base PPO network dentist**; as services from a Delta Dental Network dentist will be less expensive than services from an out-of-network dentist or a Delta Premier Network dentist.

The second option to choose from is the Delta Dental Buy-up PPO which provides a greater benefit for basic services and provides coverage for children's Orthodontics up to age 19.

You can find a list of participating PPO and Premier dentists at www.deltadentalmo.com or call 1-800-335-8266.

Delta Dental Dental Plans **Retiree** Costs

	Total Monthly Premium	KCATA Pays	Retiree Pays
Delta Dental PPO – Basic			
Retiree Only Retiree + 1 Dependent Family	$25.78 $39.29 $55.26	$0.00 $0.00 $0.00	$25.78 $39.29 $55.26
Delta Dental Buy-Up			
Retiree Only Retiree + 1 Dependent Family	$28.59 $44.08 $64.96	$0.00 $0.00 $0.00	$28.59 $44.08 $64.96

Delta Dental Basic Plan Summary of Coverage

Delta Dental Basic PPO Plan Features **Dental Benefit Highlights**[1]	Delta Dental PPO Network Based on the PPO maximum plan allowance – no balance billing	Delta Dental Premier Network Based on the Premier maximum plan allowance – no balance billing	Non-Network Based on Delta's non-participating maximum plan allowance; balance billing is possible
Diagnostic and Preventive Services ➢ Oral exams (all types), twice per calendar year ➢ Bitewing x-rays, one set per calendar year ➢ Prophylaxis (cleaning), twice per calendar year ➢ Fluoride application, once per calendar year for dependents under age 16 ➢ Emergency palliative treatment ➢ Space maintainers, once every 5 years for dependents under age 16	100%	75%	75%
Basic Services ➢ Periapical x-rays as needed ➢ Full-mouth x-rays once every 3 years ➢ Sealants for dependent children under age 16, limited to non-decayed 1st and 2nd permanent molars once per tooth every 3 years ➢ Fillings: Synthetic porcelain, plastic restorations (white) on front teeth and amalgam (silver) on molar teeth ➢ Simple extractions	50%	50%	50%
Major Services ➢ Periodontics: treatment for diseases of gums and bone supporting the teeth ➢ Endodontics: root canal filling and pulpal therapy ➢ Surgical extractions and other oral surgery ➢ Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes, once in 7 years ➢ Prosthetics: bridges and dentures; a replacement will be covered only once in 7 years, but not during the first 12 months of coverage	50%	50%	50%
Calendar Year Deductible (applies to Basic and Major Services only)	**$50 per person**	**$75 per person**	
Calendar Year Benefit Maximum	**$1,000 per person**	**$500 per person**	
Dependent Age Limit: End of the calendar year in which your dependent turns age 26.			

[1] This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services, including plan limitations and exclusions. Should discrepancies arise, the SPD will govern.

Delta Dental Buy-Up Plan Summary of Coverage

Delta Dental Buy-Up PPO Plan Features Dental Benefit Highlights[1]	Delta Dental PPO Network Based on the PPO maximum plan allowance– no balance billing	Delta Dental Premier Network Based on the Premier maximum plan allowance – no balance billing	Non-Network Based on Delta's non-participating maximum plan allowance; balance billing is possible
Diagnostic and Preventive Services ➢ Oral exams (all types), twice per calendar year ➢ Bitewing x-rays, one set per calendar year ➢ Prophylaxis (cleaning), twice per calendar year ➢ Fluoride application, once per calendar year for dependents under age 16 ➢ Emergency palliative treatment ➢ Space maintainers, once every 5 years for dependents under age 16	100%	80%	80%
Basic Services ➢ Periapical x-rays as needed ➢ Full-mouth x-rays once every 3 years ➢ Sealants for dependent children under age 16, limited to non-decayed 1st and 2nd permanent molars once per tooth every 3 years ➢ Fillings: Synthetic porcelain, plastic restorations (white) on front teeth and amalgam (silver) on molar teeth ➢ Simple extractions	80%	60%	60%
Major Services ➢ Periodontics: treatment for diseases of gums and bone supporting the teeth ➢ Endodontics: root canal filling and pulpal therapy ➢ Surgical extractions and other oral surgery ➢ Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes, once in 7 years ➢ Prosthetics: bridges and dentures; a replacement will be covered only once in 7 years, but not during the first 12 months of coverage	50%	50%	50%
Orthodontic Services ➢ For dependent children to age 19 that begin treatment while covered by this Buy-Up Plan[2]	50%	50%	50%
Calendar Year Deductible **(applies to Basic and Major Services only)**	**$50 per person**	**$75 per person**	
Calendar Year Benefit Maximum	**$1,000 per person**	**$500 per person**	
Orthodontic Lifetime Maximum	**$1,000 per eligible dependent**	**$1,000 per eligible dependent**	
Dependent Age Limit: End of the calendar year in which your dependent child turns age 26.			

[1] This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services, including plan limitations and exclusions. Should discrepancies arise, the SPD will govern.

[2] Orthodontic benefits are limited to treatment plans that begin while the eligible dependent is covered by the Buy-Up Plan. Orthodontic benefits are limited to treatment plans that begin on or after the effective date of the Buy-Up Plan, January 1, 2012. Treatment already in progress is not eligible.

Delta Dental Networks

DELTA DENTAL PPO℠ NETWORK

Comprised of a select panel of dentists, over 207,000 dental offices nationwide participate in the Delta Dental PPO℠ program. Delta Dental will provide the highest level of benefits (see benefit highlights) for covered services when care is received from a Delta Dental PPO℠ dentist. These dentists agree to:

- **Accept payment based on the applicable PPO℠ Maximum Plan Allowance** – under this network, fewer dollars accumulate towards your annual benefit maximum, your out-of-pocket expenses are typically less and you are protected from balance billing.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

Your out-of-pocket expenses will be lowest when you see a Delta Dental PPO℠ dentist.

DELTA DENTAL PREMIER® NETWORK

Comprised of over 292,000 participating dental offices nationwide, Delta Dental Premier® offers you greater access to dentists while still offering the advantages of a network. These dentists have participating agreements with Delta Dental which require them to:

- **Accept payment based on the applicable Premier® Maximum Plan Allowance** – these dentists have agreed to accept this as payment in full which means you are protected from balance billing.
- Submit dental claims for members and abide by Delta Dental's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

The Delta Dental Premier® Network offers you cost control and claims filing advantages as noted above. However, your out-of-pocket expenses (deductibles and coinsurance amounts) may be higher with a Premier® dentist, based upon your plan design.

NON-PARTICIPATING DENTIST

If you receive services from a non-participating dentist (does not participate in either Delta Dental network):

- You may be responsible for filing your own claim forms.
- Delta Dental's benefit payment will be made directly to you.
- Benefit payments will be based on Delta Dental's non-participating Maximum Plan Allowance.
- You will be responsible for the difference between the dentist's charge and Delta Dental's non-participating Maximum Plan Allowance.

Your out-of-pocket expenses may be more when you use a non-participating dentist.

Vision Insurance

Did you know that a routine eye exam can help to diagnose an array of medical conditions, including diabetes? It is just as important to get your annual eye exam as it is to get your routine medical physical. The following vision plan is available to you and your family members.

The VSP Choice Network provides one of the largest networks available. You may choose from a large number of local participating optometrists, ophthalmologists, retail locations, and any VSP affiliate retail chain which includes any Costco or VisionWorks in the greater KC area. To identify participating VSP providers, you may go to www.vsp.com or call 1-800-877-7195.

VSP Vision Plan **Retiree** Costs

	Retiree Pays Monthly
Retiree Only	$ 5.70
Retiree Plus 1 Dependent	$11.42
Family	$18.40

VSP Vision Plan

VSP Choice Network

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$25	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Scratch-resistant coating • UV protection • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $0 $0 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.[1] • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

*** Please note: You will not receive a vision card for this plan.**

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $45	Single Vision Lenses.....up to $30	Lined Trifocal Lenses.....up to $65
Contacts.....up to $105	Frame.....up to $70	Lined Bifocal Lenses.....up to $50
Progressive Lenses.....up to $50		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

[1] Brands/Promotion subject to change.

Group Term Life with AD&D

KCATA provides all Salaried and Full-time Union Retirees with group life insurance coverage at no cost to the retiree. For further details please contact KCATA Human Resources/Work Life Division.

Breen Wellness Center

KCATA retirees that have completed a current year Gym Waiver are encouraged to use the Breen Wellness Center:

- This unstaffed wellness center is available Monday-Friday 8-5pm via reception desk check-in
- Blood Pressure Kiosk available in center

Retiree and Dependent Bus Passes

The KCATA Human Resources/Work Life Division annually distributes retiree and dependent passes for the upcoming year the last week of December. Passes will be honored on all services operated by the KCATA for eligible dependent children between the ages of 5 and 26.

Retiree passes are issued for a two-calendar-year period. All passes must contain the picture of the dependent and/or retiree utilizing the pass. Pictures for 2018 bus passes will be taken in the KCATA Human Resources/Work Life Division November 6 — December 15, 2017, if a picture is not on file.

Dependent passes are available for eligible dependents of:

- KCATA retirees and spouses; and
- The widow/widower of a KCATA retiree who worked five or more years with the Authority preceding death, who has not remarried.

NOTE: Lost passes will require a two-week waiting period and a $20 fee before replacement. Confiscated passes will require a two-month wait, if replaced at all. See the policy for more details. Proof of eligibility is required for all passes. Applications are available at www.kcata-retiree-benefits.com or in the Human Resources/Work Life Division.

Glossary

Deductible

The deductible is the amount of your covered expenses you must pay each calendar year before the insurance company begins to pay. The individual deductible is the amount each covered family member must pay before the insurance company begins to pay. However, every dollar applied to the individual deductible will also be applied to the family deductible. Once the family deductible is met, the plan will pay benefits for all family members.

Coinsurance

After the deductible is met, you and the insurance company share in the payment of your medical bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers are utilized.

Covered Expenses

Covered expenses are the expenses that are eligible for reimbursement. All of the medical coverage options generally provide benefits for medically necessary services and supplies ordered by a doctor for the treatment of an accidental injury, sickness or pregnancy. Each option also provides benefits for certain routine and preventive services. Under all plans, when benefits are paid for out-of-network covered expenses, the insurance company will consider payment of those expenses only up to Reasonable and Customary (R&C) limits.

Copayment

Copayment refers to a fixed cost that you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician and pharmacy).

In-Network

In-network coverage is provided for covered expenses when you receive treatment or services from a provider or hospital which is a member of the insurance company plan provider network. In-network coverage is the highest level of coverage provided.

Out-of-Network

Out-of-Network coverage is provided for covered expenses incurred when you receive treatment or services from a provider or hospital which is not a member of the insurance company plan provider network. The plan considers covered expenses only up to Reasonable and Customary (R&C).

Out-of-Pocket Maximum

This maximum limits your out-of-pocket expenses (including deductibles, medical copayments and coinsurance) in any one calendar year. If you reach the individual out-of-pocket maximum for any covered family member, the plan pays 100% of that person's covered expenses for the remainder of the year. If you reach the family out-of-pocket maximum, the plan pays 100% of your entire family's covered expenses for the remainder of the year. Please note that any prescription drug copayments as well as expenses not covered by the plan do not count towards the out-of-pocket maximum and remain the participant’s responsibility to pay even after the out-of-pocket maximum is reached.

Reasonable and Customary

The insurance company plans will not pay for any charge above *Reasonable and Customary (R&C)* limit when you receive services from out-of-network providers, and these charges do not count towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services and supplies in your geographic area. The insurance company determines whether or not a charge is reasonable and customary and keeps up-to-date with the latest medical practices and fees around the country. Because in-network providers and hospitals provide services and supplies for agreed-upon rates, you will never exceed R&C charges when you use in-network providers.

Annual Notices

HIPAA Privacy Notice - Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive.

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- Help with public health and safety issues. We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Do research. We can use or share your information for health research.
- Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests

  We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. This notice applies to the Kansas City Area Transportation Authority. If you would like to pursue any of your individual rights regarding your PHI, contact Human Resources/Work Life Division, Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108. You have the right to contact U.S. Department of Health and Human Services' Office for Civil Rights (OCR) if you have any complaints about how the Plan has handled your PHI. You can submit your complaint online, or download a complaint form at this OCR website (http://cms.hhs.gov/hipaa). Or, you can send your complaint or question to this e-mail address: askhipaa@cms.hhs.gov. Or, you can call the CMS HIPAA Hotline: 1-866-282- 0659. This notice becomes effective on April 14, 2003.

COBRA – Initial (General) COBRA Notice Continuation Coverage Rights under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Kansas City Area Transportation Authority, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources/Work Life Division, Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108. A written notice is required as well as proof of the qualifying event.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
You must provide proof of disability to the Plan Administrator (i.e. letter of determination from the Social Security Administration.

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

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Human Resources/Work Life Division
Kansas City Area Transportation Authority
1200 East 18th Street
Kansas City, MO 64108

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 towards your or your dependents' other coverage). However you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage.) This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding your or your dependents' other coverage on your initial enrollment form/waiver.

In addition, if you acquire 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.

You may also be eligible for a Special Enrollment Period if you and/or your dependents are determined to be eligible for premium assistance under a state Medicaid plan or state child health plan. You must request enrollment within 60 days of the date you are determined to be eligible for this premium assistance.

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

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. Contact your Plan Administrator Human Resources/Work Life Division, Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108 for more information.

Medicare Part D Notice – Medicare Part D Notice for Base HMO, Buy-Up HMO and PPO Plan Participants – Important Notice from Kansas City Area Transportation Authority 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 Kansas City Area Transportation Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Kansas City Area Transportation Authority has determined that the prescription drug coverage offered by the Kansas City Area Transportation Authority Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Kansas City Area Transportation Authority coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Kansas City Area Transportation Authority coverage, be aware that you and your dependents may be able to get this coverage back provided you are a benefits eligible employee.

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

You should also know that if you drop or lose your current coverage with Kansas City Area Transportation Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kansas City Area Transportation Authority 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 http://www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2017
Name of Entity/Sender: Kansas City Area Transportation Authority
Contact--Position/Office: Human Resources/Work Life Division
Address: Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108
Phone: 816-221-0660

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.

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 are 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 are not 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 are not 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. Contact your State for more information on eligibility –

KANSAS – Medicaid

Website:
http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

To see if other states have a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Grandfathered Health Plan Notice

Blue Cross Blue Shield of Kansas City and the KCATA believes the Blue-Care medical plans and the Preferred-Care Blue are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Human Resources/Work Life Division, Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108

Notice Regarding Wellness Program

The Kansas City Area Transportation Authority wellbeing program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a discount on their medical premiums for completing the Health Risk Assessment and Biometric Screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a discount on their medical premiums.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and KCATA may use aggregate information it collects to design a program based on identified health risks in the workplace, the Kansas City Area Transportation Authority wellbeing program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources/Work Life Division, Kansas City Area Transportation Authority, 1200 East 18th Street, Kansas City, MO 64108.