Helping You Become a Better You.

2020 Employee Benefits Guide

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

Non-Discrimination Disclosure

It is the policy of the School District of Clayton not to discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs or employment practices as required by Title VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title II of the Americans with Disabilities Act of 1990.

Behavior that is not unlawful or does not rise to the level of illegal discrimination or harassment might be unacceptable for the workplace or the educational environment. Demeaning or otherwise harmful actions are prohibited, particularly if directed at personal characteristics. Accordingly, the District prohibits discrimination or harassment on the basis of sexual orientation, perceived sexual orientation or gender identity.

Inquiries related to the District's employment practices should be directed to Dr. Tony Arnold, School District of Clayton, #2 Mark Twain Circle, Clayton, Missouri 63105 or by phone at 314.854.6012. Inquiries related to the District's student programs should be directed to Dr. Robyn Wiens, Assistant Superintendent of Student Services, School District of Clayton, #2 Mark Twain Circle, Clayton, Missouri, 63105 or by phone at 314.854.6013.

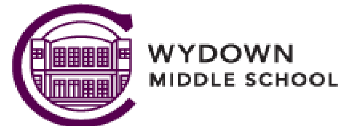
Inquiries or concerns regarding civil rights compliance by school districts should be directed to the local school district Title IX/non -discrimination coordinator. Inquiries and complaints may also be directed to the Kansas City Office, Office for Civil Rights, US Department of Education, 8930 Ward Parkway, Suite 2037, Kansas City, MO 64114; 816.268.0550; TDD 877.521.2172.

School District of Clayton

#2 Mark Twain Circle

Clayton, Missouri 63105

(314) 854-6000



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CONTACTS

The School District of Clayton in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or call the Business Office at ext 6011.

Medical
Anthem
Group Number: W60496
anthem.com
800.490.6145

Dental
Delta Dental
Group Number: 01190301
deltadentalmo.com
800.335.8266

Cigna DHMO
Group Number: 10050105
Cigna.com
800.244.6224

Vision
EyeMed
Group Number: 1018839
eyemed.com
866.939.3633

Basic Life/AD&D, Voluntary Life/AD&D, & LTD
Axa
Group Number: 04320
axaebcustomerservcie@axa.us.com
888.292.4636

Employee Assistance Program (EAP)
PAS
paseap.com
800.356.0845
Organizational Code: 0094

Flexible Spending Account
CBIZ Flex
myplans.cbiz.com
800.815.3023
Fax: 800.584.4185

CSD Retirement Trust—AIG
Shane Hurst
314-439-4850
Shane.hurst@aig.com

CBIZ Consultants
Donna Clifton
dclifton@cbiz.com
314.692.5812

Eric File
efile@cbiz.com
314.692.5848

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INTRODUCTION

Understanding Your Plan Options

When the School District of Clayton reviews our employee benefits options, we focus not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We are proud to offer a broad benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this booklet.

You may share the costs of some benefits, and the School District of Clayton provides other benefits at no cost to you. In addition, there are voluntary benefits with reasonable group rates that you can purchase through the School District of Clayton with payroll deductions.

Benefits Offered

- **Three medical** plans administered by Anthem: a Base Plan, Buy-Up Plan, and a Qualified High Deductible Health Plan (QHDHP). If you select the QHDHP, the District contributes $125 per month from the allotment into your Health Savings Account.
- Each medical plan offers a choice of either the Blue Access Choice network which includes the BJC provider network or the Blue Preferred Select which does not include the BJC provider network.
- **Two dental plans—**one is offered through Delta Dental PPO and the other through Cigna DHMO.
- **Vision** plan through Eyemed.
- **Basic Life / AD&D and Supplemental Life / AD&D** offered through Axa.
- **Long-Term Disability** offered through Axa.
- **Worksite** products to include Critical Illness, Accident and Universal Life with Long-Term Care offered through Trustmark.
- The District offers eligible employees an allotment to pay for the employee cost of the Medical Base Plan, Delta Dental and EyeMed Vision plan. The 2020 total allotment is **$770.48** per month per eligible employee.
- The District offers an $1,800 stipend to any employee who elects to waive their medical coverage. The stipend is divided equally over the course of the plan year on each pay date. You must be eligible for the medical insurance and prove you are covered elsewhere. A signed waiver is required and the stipend is paid as taxable income.

What's Inside?
This brochure provides an overview of your benefit options. If you have any questions after you enroll, please call the carriers directly or log on to their websites.

Eligibility

The Board defines a benefit eligible, full-time employee as a staff member the District reasonably expects to work an average of 30 hours or more per week. Eligible employees who are hired on a full-time basis, and the letter of employment or contract start date is the first day of the month, are eligible for coverage on this date. All other full-time employees are eligible for coverage on the first day of the following month.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Your legal spouse
- Your or your spouse's child who is under age 26
- Legally adopted child or a child placed for adoption
- Child for which you or your spouse is the legal guardian
- A disabled child who is unmarried and over age 26
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court order

Ineligible:

- A common law spouse/domestic partner
- Divorced or legally separated spouse
- Foster children
- Sisters, brothers, parents, or in-laws, grandchildren, etc.

Frequently Asked Questions

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the open enrollment period or when you are first hired. However, you may make changes/enroll during the plan year if you experience a Qualifying Life Event (QLE). As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying life event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; see your Human Resources department for details.

EXAMPLES OF QUALIFYING EVENTS?

- You have a baby or adopt a child
- Gain or loss of Medicaid entitlement
- You or your spouse take an unpaid leave of absence
- Death of an insured member
- You become eligible for Medicare
- You get married, divorced, or legally separated (with court order)
- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions

Medical Plans

Below is a summary of the three medical plan options available beginning January 1, 2020. It is to your advantage to use in-network providers. If you go out-of-network, you will be responsible for any amount exceeding Anthem's negotiated discounts plus any deductible and co-insurance associated with your procedure.

The in-network benefits for each plan are illustrated side-by-side below so that you can compare them. Please refer to the Anthem Benefit Summaries for out-of-network-benefits associated with each of these options and more detailed information.

Plan Designs - Administered by Anthem

Features	Base Plan	Buy-Up Plan	Qualified High Deductible Health Plan*
Deductible *(per calendar year)* (Individual / Family)	$750/$1,500	$300/$600	$3,000 / $6,000 (Embedded)
Deductible is Calendar Year			
Out-of-Pocket Maximum *(per calendar year)* *(includes deductibles & copays - RX copays do not apply for Base and High Plans)* (Individual / Family)	$3,500/$7,000	$3,000/$6,000	$4,000/$8,000
Coinsurance *(the amount the plan pays)*	80%	90%	90%
Office Visits (Preventive—100% in-network)	$30 Primary Care Physician $60 Specialist	$25 Primary Care Physician $50 Specialist	Deductible & Coinsurance
LiveHealth Online	$30 Copay	$25 Copay	$49 Copay after deductible
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Lab, X-Ray and Diagnostic	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	$50 Copay	$50 Co-Pay	Deductible & Coinsurance
Emergency Room	$300 Copay	$200 Co-Pay	Deductible & Coinsurance
Prescription Drug Retail Pharmacy Mail Order Pharmacy	$10 / $40 / $70 / $150 2 Copays	$10 / $40 / $70 / $150 2 Copays	Deductible & Coinsurance Deductible & Coinsurance

*If you elect to enroll in the Qualified High Deductible Health Plan (QHDHP), you are required to enroll in the Health Savings Account. The District requires $125 per month from the benefit allocation to be deposited into your Health Savings Account.

You will receive a monthly benefit allotment of **$725** from which your medical cost will be deducted. If you choose to "waive" the medical coverage, you will receive a monthly opt out allocation of **$150**. In order to receive this allocation, you must return the "waiver form" to the Business Office. This form is available on the Benefit Allocation page on the enrollment website.

New for 2020, the School District of Clayton is offering employees the ability to choose from two networks.

- **Full Network**—This network includes all the hospitals and affiliated physicians in the Anthem network. This is the **Anthem Blue Access Choice** network.
- **Narrow Network (No BJC)** - The narrow network plans have a lower premium (approximately 6% lower), but as a trade-off, your choice of providers is limited. This network **excludes** all BJC hospitals and affiliated physicians. This is the **Anthem Blue Preferred** network.

Medical Plan Network Options

Medical Plan Network Options

It is important to know your network, and the providers in it, to avoid high out-of-pocket costs due to being out-of-network.

- **You might consider a narrow network if you are healthy.** The lower premium may balance out the smaller network if you usually only visit your doctor for regular health exams. Narrow networks can be enough if you don't see a lot of specialists or need many medical tests.
- **You might need a larger network if you or a family member needs a lot of care.** Suppose you have a chronic health problem like diabetes or heart disease. A narrow network could limit your choices. If you leave your network, your out-of-pocket costs could add up quickly.

Be sure to study each network with care to make sure you are able to visit your regular providers. Search the plan's list of providers (available online) by your zip code. See if your provider or how many other providers are close to where you live and work. Below is a sample list of hospitals that are **not** included in the narrow network:

- Alton Memorial
- All Barnes-Jewish Hospitals
- Boone Hospital
- Christian Hospital
- Goldfarb School of Nursing
- Memorial Hospital East & Belleville
- Missouri Baptist Medical Center & Sullivan
- Northwest Healthcare
- Parkland Health Center
- Progress West Hospital
- Rehab Institute of St. Louis
- St. Louis Children's Hospital
- Washington University

This is not complete list of excluded providers. Be sure to check with your provider to confirm which network they are affiliated with. This also applies to urgent care, outpatient and imaging centers. A complete list of providers can be found on the Anthem website.

If you enroll in the narrow network option, you will be required to sign a document stating you understand the provisions of this plan and that if you go to a BJC provider in this option for a non-emergency visit, the cost will be subject to your out-of-network benefits.

Monthly Medical Employee Cost

Coverage Type	Base Plan		Buy-Up Plan		QHDHP	
	Full Network	Narrow Network	Full Network	Narrow Network	Full Network	Narrow Network
Employee	$0.00	$0.00	$140.00	$89.00	$0.00	$0.00
Employee/Spouse	$490.00	$410.00	$785.00	$687.00	$265.00	$210.00
Employee/Children	$275.00	$208.00	$525.00	$443.00	$115.00	$66.00
Family	$805.00	$700.00	$1,245.00	$1,115.00	$540.00	$460.00

Anthem Health & Wellness Resources

As an Anthem member, you have access to health and wellness tools that can change the way you think about healthcare and how you use your benefits. They were designed with YOU in mind, so you can use them when and where you want to.

SYNDEY—Anthem's newest app is simple, smart and all about YOU. With Sydney you can find everything you need to know about your Anthem benefits—personalized and all in one place. Sydney makes it easier to get things done, so you can spend more time focused on your health.

myStrength—is a free online and mobile program that supports emotional health and well-being. The program's tools and resources are available to help you manage addiction, depression, anxiety, sleep problems, chronic pain and stress. To access myStrength, visit anthem.com/mystrengthMO. After you are registered online, you can download the myStrength app for easy access wherever you are.

MyHealth Advantage connects your claims, doctor reports, personal health history and other information for a bigger picture of your health. If we see things you can act on to help improve your health or save money, you'll get a MyHealth Note—a confidential health summary that includes money-saving tips, prescription drug updates, reminders for checkups, tests and exams, list of recent claims and general health tips. The program can help you keep health issues from developing or becoming serious. And that means lower health care costs down the road. MyHealth Notes can also be accessed through the Sydney app.

LiveHealth Online. Visit a doctor 24/7 to get expert advice, a treatment plan and prescriptions if needed. Whether you have a medical issue, allergy concern or need behavioral health services, LiveHealth Online can help. It's free to sign up, there are no monthly fees. Simply sign up or log in, select a doctor and feel better fast. Sign up at livehealthonline.com or download the app by searching LiveHealth Online in the App Store or Plan Store. LiveHealth Online can also be accessed through the Sydney app.

LiveHealth Online Psychology. You can get help for conditions such as stress; anxiety; depression; family or relationship issues; grief; panic attacks; stress from coping with a sickness.

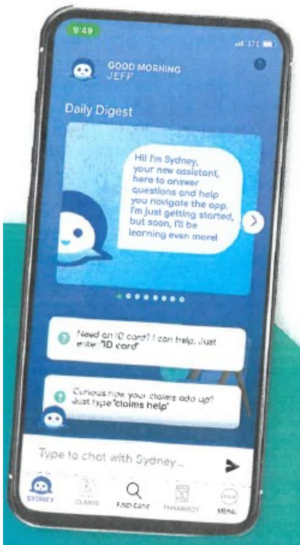
ConditionCare. Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your goals based on your doctor's plan. You can work with dietitians, health educators, pharmacists and social workers to reach those goals and feel your best. After you select your plan, you can sign up for ConditionCare by calling 866-962-1069.

24/7 NurseLine. Registered nurses can answer our health questions wherever you are—anytime, day or night by calling 800-337-4770/

Future Mom. Moms-to-be get personalized support and guidance from registered nurses to help them have a healthy pregnancy, a safe delivery and a health baby. After you select your plan, you an sign up for Future Moms by calling 800-828-5891.

Anthem.com—Health and Wellness Resources. Anthem's online wellness health support is your one-stop shp for health and wellness resources. The programs help you achieve your health goals by providing a personalized action plan, plus access to both Anthem and WebMD health improvement programs. To access the online wellness help support, visit anthem.com and select Health and Wellness Center under the Care tab.

Anthem Health & Wellness Resources (con't)



Get Started with Sydney.

To download the app:

- On your Apple device, open App Store. On your Android device, open Play Store.
- Enter Sydney into the search bar and select Download.

Once downloaded, the Sydney logo will appear on your device.

Already using the Anthem app? It's easy to make the switch. Simply download the Sydney app and log in with your Anthem username and password.

Health Savings Account (HSA)

What is an HSA?

A savings account set up by either you or your company where you can either direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours forever - the HSA is in your name, just like a personal checking or savings account.

Why would I want an HSA?

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions do NOT count toward your taxable income for federal taxes.

What Rules Must I Follow?

- You must be covered under a *Qualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if your spouse has a medical *flexible spending account (FSA) through their employer.*
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse’s employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare or Tricare.
- You cannot be claimed as a dependent under someone else’s tax return.

What is the Difference Between a Qualified High Deductible Health Plan and a Traditional PPO Plan?

In a QHDHP, all services received, with the exception of preventive office visits, are applied to the deductible and coinsurance first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

What Else Do I Need to Know?

- The IRS sets the contribution limits yearly, which are listed under “Total Annual Maximum Contribution” in the table below. You cannot put more than this amount in the account in a calendar year; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services (medical, dental, vision and over-the-counter medically necessary items).

	2020 Total Annual Maximum Contribution
Employee	$3,550
Employee + Family	$7,100

- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty, but you will pay income taxes.
- The savings account can be established with your employer, so you can take advantage of payroll deductions on a pre-tax basis.

Health Savings Account (HSA) cont'd.

Facts and tips

Your account can grow over time…

Since the money always belongs to you, even if you leave The School District of Clayton, any unused funds carry over from year to year, so you never have to worry about losing your money. That means if you do not use a lot of healthcare services now, your HSA funds will be there if you need them in the future – even after retirement.

HSA's are also an investment opportunity…

With an HSA, your account can grow tax-free in an interest-bearing savings account, a money market account, a wide variety of mutual funds – or all three. Of course, your funds are always available if you need them for qualified healthcare expenses.

Generally, you can put enough in your HSA to cover most of your deductible.

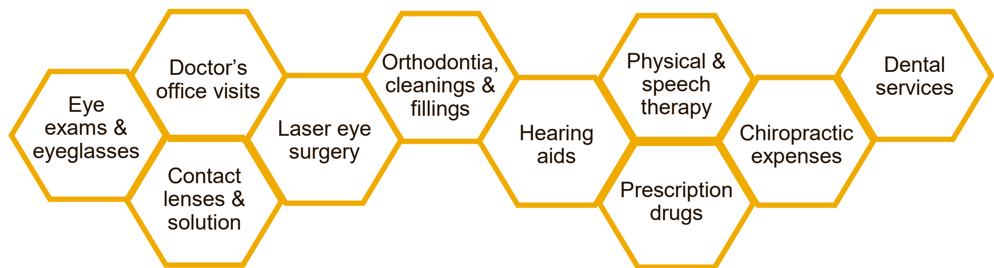
The Qualified High Deductible Health Plan helps you pay for healthcare AFTER you meet the deductible. The annual contribution limit is based on IRS rules. In general, the total amount that goes in your account each year cannot be more than the IRS annual contribution limit. If you are age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

You can spend only the money that is actually in your HSA.

If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as cash or personal check. You can request reimbursement after you have accumulated more money.

You can use your HSA for your spouse and dependents – even if they are not covered by your High Deductible Health Plan.

You can use HSA funds for IRS-approved items such as…



More information about approved items, plus additional details about the HSA, is available on the IRS Website at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay taxes and a penalty on the ineligible amount.

Facts and tips

You have options when it comes to you or your loved ones' care. This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

Primary Care	• Routine, primary/ preventive care • Non-urgent treatment	
Virtual Visits	• Cold/flu • Diarrhea • Fever	• Rash • Sinus Problems
Convenience Care	• Common infection (ear infections, pink eye, strep throat) • Flu shots • Pregnancy tests	
Urgent Care	• Sprains • Small cuts • Strains • Sore throats	• Minor infections • Vaccinations • Screenings
Emergency Room	• Heavy bleeding • Large open wounds • Chest pain	• Spinal injuries • Difficulty breathing • Major burns

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting anthem.com.

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PRIMARY CARE - For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

VIRTUAL VISITS - Lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! Anthem's LiveHealth Online brings you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE - Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit Anthem's website at anthem.com.

URGENT CARE - Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours, you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Care Options cont'd.

Services that are available for urgent care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting Anthem's website at anthem.com.

LAB SERVICES - Both Quest and LabCorp are Anthem preferred labs.

EMERGENCY ROOM - If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. An emergency medical condition is any condition (including severe pain), which you believe that without immediate medical care may result in:

- Serious jeopardy to you or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to you or your loved one's bodily functions
- Serious dysfunction of any of you or your loved one's bodily organ or part

If you obtain care at an emergency room, you will likely pay more out-of-pocket than if you were treated at your doctor's office, a Convenience Care Center or Urgent Care facility.

PRESCRIPTION BENEFITS - Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Anthem and approved before they are covered. This process, called *prior authorization*, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for The School District of Clayton and potentially lower future renewal increases. Some prescription drugs are covered only if the physician obtains prior authorization from Anthem. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE - Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a network provider. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at **healthcare.gov**.

WOMEN'S PREVENTIVE CARE COVERAGE - Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (copayment, coinsurance or deductible), when delivered by in-network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in-network pharmacy.

Dental Insurance—Delta Dental PPO

Facts and tips

You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the Delta program, your out-of-pocket expenses may be greater, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating dentist, you are only responsible for the difference between the in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

To find a participating dentist, visit deltadentalmo.com. The list of available dentists is not guaranteed and it is advisable to ask your dentist if they are currently participating or accepting new patients. Although the Delta Dental PPO plan allows you the freedom to visit any licensed dentist, you will save more on your out of pocket costs when you visit a Delta PPO dentist. The Delta Premier network also provides cost saving features and is the next best option. The dentist you choose could affect your cost.

Plan Design - Administered by Delta Dental of Missouri

Features	PPO	Premier
Deductible *(Calendar Year)* (Individual / Family)	$50 / $150	$50 / $150
Type I - Preventive Care: (Exams, Cleanings)	100% (No Ded.)	100% (No Ded.)
Type II—Basic Procedures: (Fillings, Extractions)	90%	80%
Type III—Major Procedures: (Caps, Crowns)	60%	50%
Endodontics:	90%	80%
Periodontics:	90%	80%
Type IV—Orthodontia:	50% to $1,000 Lifetime Maximum	50% to $1,000 Lifetime Maximum
Maximum Benefits/Year	$1,500	$1,500

- Certain services may have frequency and/or age limitations. The limits are described in the Delta Dental Certificate of Coverage or you can contact Delta Customer service for specific details.

Monthly Dental Employee Cost

Coverage Type	
Employee	$0
Employee/Spouse	$41.09
Employee/Children	$53.63
Family	$94.34

The amounts shown are the employee contributions after the **$41.08** monthly dental benefit allotment.

Facts and tips

- You are responsible for a **$5 office visit** fee per patient, per office visit.
- You have to be on the dentist's roster in order to receive treatment.
- Check the **Patient Charge Schedule K1-V9** before receiving services to know your responsibility.
- The Patient Charge Schedule K1-V9 is located in the **EMB Resource** page, or you can contact the Business Office for a copy.
- If a procedure is not shown in the schedule, it is **not covered**.

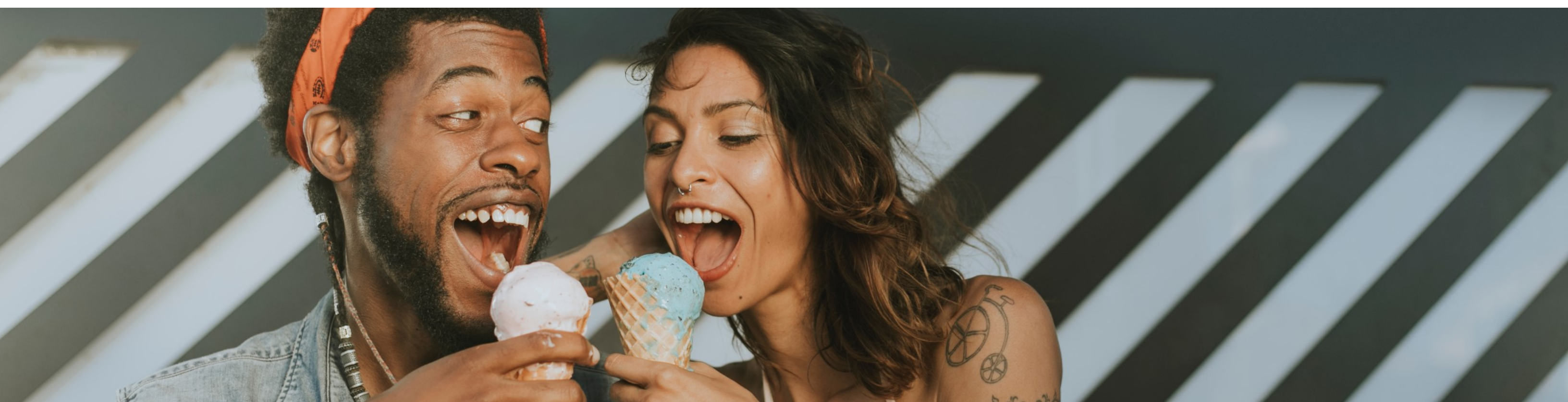
Monthly Dental Employee Cost

Coverage Type		Allotment Balance
Employee	$0	($14.41)
Employee & Spouse	$5.66	$0
Employee & Child(ren)	$8.38	$0
Employee & Family	$33.88	$0

Following is a sample schedule of the Cigna DHMO patient charge schedule:

CODE	PROCEDURE	PATIENT PAYS
D1110	Adult Cleaning	No Charge
D0270	Bitewings	No Charge
D0330	Panoramic X-Ray	No Charge
D2330	Composite - Surface	No Charge
D2140	Amalgam - 1 surface	No Charge
D2752	Crown - Porcelain	$425
D6794	Crown - Titanium	$460
D3310	Root Canal - Anterior	$210
D3320	Root Canal - Bicuspid	$245
D3330	Root Canal - Molar	$335
D4210	Gingivectomy 4 per Quad	$180
D5110	Full Upper Denture	$625
D5120	Full Lower Denture	$625
D6065	Implant supported porcelain/ ceramic crown	$790
Ortho	24-Month Treatment Fee	$2,040

The amounts shown are the employee contributions after the **$41.08** monthly dental benefit allotment.



Vision Insurance—EyeMed

The District provides vision insurance for employees at no cost. You may elect coverage for your spouse and/or children; however, you will be responsible for the premium to cover your dependents. Please notice out-of-network services only provide a reimbursement benefit. You will have to pay for services first then file a claim with EyeMed.

Plan Design - Administered by EyeMed

Coverage Type	In-Network	Out-of-Network
Examination Co-Pay	$0 Co-Pay	Up to $35 Reimbursement
Lenses: Single Bifocal Trifocal	$5 Copay; then: $0 Copay $0 Copay $0 Copay	Allowance $35 $45 $60
Frame	$50 Wholesale Allowance $125 to $150 Retail	$35 Retail Allowance
Contact Lenses: Necessary Elective	 UCR $130 Allowance	 $250 Allowance $130 Allowance

You will receive a monthly benefit allotment of $4.40 from which your vision cost will be deducted.

Facts and tips

Frequency of Service:

Exam: Every 12 months
Lenses: Every 12 months
Frames: Every 24 months

- Contact lens allowance is for lenses. In-network providers are contracted to charge no more than $40 for the standard contact lens fit and follow up exam.
- UCR refers to Usual, Customary and Reasonable charges. To determine the UCR, EyeMed takes the procedural charge of area providers and calculates an average. Charges above this average become your responsibility.

Monthly Vision Employee Cost

Coverage Type	
Employee	$0
Employee & Spouse	$3.96
Employee & Child(ren)	$4.40
Employee & Family	$8.54

The amounts shown above are the employee contributions after the **$4.40** monthly vision benefit allotment

Employee Assistance Program (EAP)

Administered by Personal Assistance Services (PAS)

EAP services are confidential assistance for you and your eligible dependents. It provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the below services to help you balance work and home life.

PAS specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. Their professionals answer calls 24 hours a day, seven days a week. When you call 314.842.6223 or 1.800.356.0845, a representative will answer any questions you have and set up an appointment for you. Please visit the PAS website for additional information at paseap.com.

- Marital/relationship concerns
- Parenting challenges
- Financial planning
- Budget/debt problems
- Identity theft
- Job stress
- Legal concerns
- Child care resources and referral
- Education and college planning
- Elder care planning and management
- Emotional health and wellness
- Substance abuse
- Tobacco cessation
- Healthy eating and exercise
- Household management

Basic Life and Accidental Death & Dismemberment (AD&D)

Administered by Axa, the District provides Basic Life and Accidental Death & Dismemberment coverage to all eligible employees. This coverage is provided by the District at no cost to you. In the event of your death, your beneficiary will receive $50,000. The AD&D benefit is equal to your basic group life insurance in case of death.

Voluntary Life and Accidental Death & Dismemberment (AD&D)

Administered by Axa, the District offers eligible employees the option to purchase voluntary life insurance for yourself, your spouse, and/or your dependent child(ren). Any amount in excess of the guaranteed issue limit requires completion of an Evidence of Insurability form. Coverage will go into effect once Axa approves your application.

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to the lesser of $500,000 or 5 times your salary. Guaranteed Issue amount is $200,000 without evidence of insurability.

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $200,000. Guaranteed issue amount is $25,000 without evidence of insurability.

CHILDREN

Coverage is available for your children up to age 26 whether they are a full-time student or not. You can elect coverage of $10,000. The amount you select is for each child you cover. The cost is based upon the family unit and not each child. Guarantee issue does not apply to child coverage.

Voluntary AD&D must match your elected Voluntary Life coverage. Example: if you elect $100,000 of Voluntary Life insurance, your elected Voluntary AD&D coverage must also be $100,000.

Monthly Voluntary Life Employee Rate

Age Band	Rate Per $1,000
Under Age 30	$ .033
30 - 34	$ .038
35 - 39	$ .049
40 - 44	$ .073
45 - 49	$ .115
50 - 54	$ .180
55 - 59	$ .275
60 - 64	$ .388
65 - 69	$ .691
70+	$1.149
Child	$ .240

Monthly Voluntary AD&D Employee Rate

Rate per $1,000 of Coverage	Rate Per $1,000
Single	$.017
Spouse	$.017
Child(ren)	$.049

Amount of coverage must match your elected Voluntary Life coverage.

HOW TO CALCULATE

$50,000 Elected Coverage	÷ 1,000 =	50 Units	X	$.132 Rate * See Note	=	$ 6.60 Per Month

*The premium calculation is based upon the life and AD&D rate for an employee age 45.

Long-Term Disability

Administered by Axa

The School District of Clayton provides you with Long-Term Disability (LTD) protection. This benefit protects your income to age 65 if you are totally disabled. Following are some key components of the plan:

- 180 day waiting period before benefits begin.
- 66 2/3% salary reimbursement to $12,500 per month maximum.
- Benefits are payable for 3 years if you are unable to perform your occupation. Benefits are available to age 65 if your are totally disabled and unable to perform any occupation.

SUPPLEMENTAL BENEFITS

Voluntary Worksite Policies—Trustmark

Administered by Trustmark—three supplemental benefit options are offered to you on a voluntary basis. These benefit plans are offered only during the enrollment process. If you elect any of these worksite benefit programs, premiums will be deducted from your paycheck.

Critical Illness insurance pays a cash benefit if you are faced with a covered critical illness like cancer, heart attack or stroke.

We know that everyone has different needs and ways of coping with a critical illness. That is why you can choose how to spend or save your cash benefit. It can be used for expenses beyond direct medical costs, including:

- Paying for child care or help around the house
- Travel costs to see a specialist
- Medical treatment and doctor visits
- Copays and deductibles
- Prescription drug costs

Accidental Injury insurance gives you a cash benefit for covered accidents. You can use it to help pay for expenses associated with a covered injury.

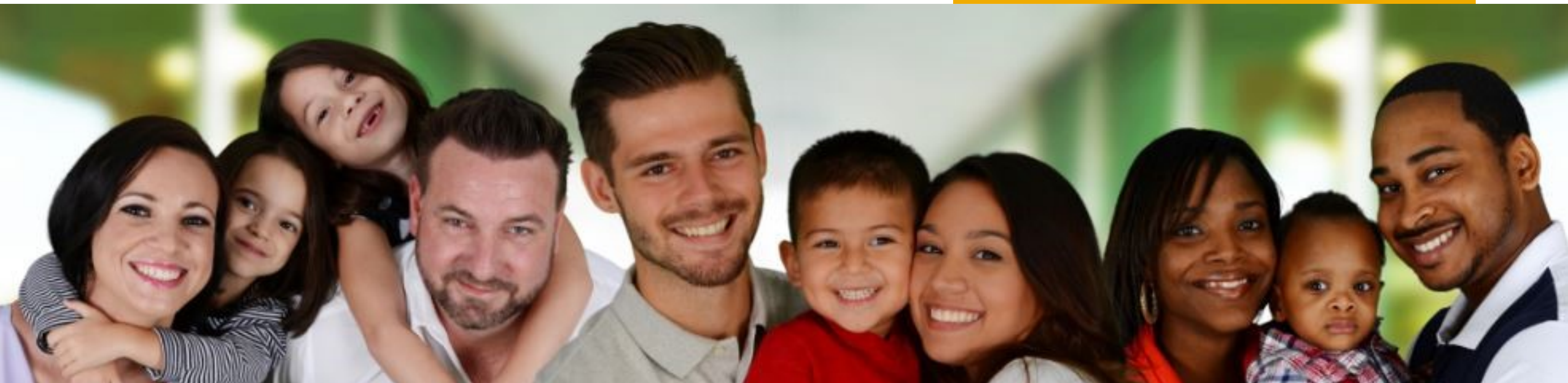
Accidents happen and can affect your financial health. Trustmark wants to help you and your family be more protected from out-of-pocket expenses like copays or hospitalization costs. The payments you receive for covered accidents can be used however you wish and are not limited to direct medical costs. For example, you can use the money to help pay for things like:

- Rehabilitation and therapy expenses
- Cover unexpected expenses

Universal Life Insurance with Long Term Care

- With this coverage you will receive permanent life insurance protection. Long-Term Care benefits and life insurance are combined. You will also benefit from a higher death benefit during the working years and a higher living benefit for long term care.

Did you Know?
When you experience a major health event, supplemental insurance policies help pay for many expenses that aren't covered by your primary health insurance.



Flexible Spending Accounts

Administered by CBIZ Flex, Flexible Spending Accounts allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. Open enrollment allows you the opportunity to enroll in and/or increase your election amounts for your Flexible Spending Account. Therefore, now is the time to gauge how much you utilize your benefits and how much money you spend in deductibles and copayments each year so that you can properly enroll in the FSA.

Medical Reimbursement Account

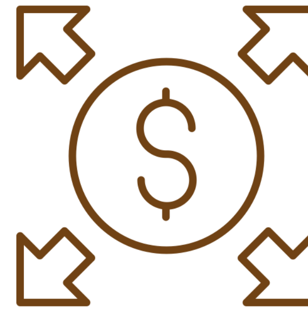
This account allows employees the opportunity to pay for eligible medical, dental, and vision expenses that are not paid in full through insurance coverage. Many members use this account for deductible amounts, copayments, eyeglasses, over the counter medications with a physician's prescription, root canals, etc. You may contribute a maximum of $2,700 annually, measured January 1 through December 31. You cannot contribute to this account if you are enrolled in the QHDHP.

Dependent Care Reimbursement Account

May be used to set aside pre-tax dollars that are used to pay for daycare expenses for a child under age 13 or the care of a disabled spouse or dependent of any age. You and your spouse must both work or be full-time students to qualify.

You are allowed to contribute a maximum of $5,000 annually to the Dependent Care FSA if you are married and filing a joint tax return or are filing a single head of household tax return.

Married couples filing separate returns are allowed to claim a maximum of $2,500 each. In most cases, there is substantially more tax savings with this plan than there is with the "tax credit" that you get when doing your tax return. It is best to discuss your options with your tax advisor if you have any concerns.



Facts and tips

Tracking your health care deductibles can help you make better decisions at open enrollment time when considering a Medical Reimbursement Account. Know the following:

- The total amount of your deductibles
- What expenses don't count towards your deductible
- How often you actually meet your deductible
- Medical exams or services you'll need during the year

Below is a partial list of eligible expenses that can be reimbursed from a Medical Reimbursement Account. Other out-of-pocket expenses may qualify.	
Alcoholism treatment	Laboratory fees
Artificial limbs	Licensed osteopaths
Ambulance	Licensed practical nurses
Braces	Orthodontia
Chiropractors	Orthopedic shoes
Coinsurance and copayments	Obstetrical expenses
Contact lens solution	Oxygen
Contraceptives	Prescription drugs
Crutches	Podiatrists
Deductible amounts	Prescribed vitamin Supplements (medically necessary)
Dental expenses	Psychiatric care
Dentures	Psychologist expenses
Dermatologists	Routine physical
Diagnostic expenses	Seeing-eye dog expenses
Eyeglasses, including exam fee	Smoking cessation programs
Handicapped care and support	Sterilization and reversals
Nutrition counseling	Substance abuse treatment
Hearing devices and batteries	Surgical expenses
Hospital bills	

How to Enroll

Visit our benefits portal to review your benefit guide, Important documents and watch benefit education videos.

ExplainMyBenefits.com/clayton

Enroll in the Online system

School District of Clayton provides electronic enrollment through Explain My Benefits. Explain My Benefits provides eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events.

Enrollment has never been easier. Accessible 24 hours a day, information about all of your employee benefit election options, including premiums and carrier contact information are available to help you make informed decisions.

You can also log into the Explain My Benefits portal at anytime or download the Mobile App, to review your benefits, access carrier links, update your personal information for yourself and your dependents, update your beneficiaries and process qualifying life events.

Self-Service

Visit explainmybenefits.com/clayton on any computer, click on the blue “Log into Your Benefit System” button and move through the enrollment system at your own pace. ***Or, download the new Mobile App on your phone or tablet and move through the enrollment at your own pace.***

Be sure to click “submit” at the end of the process and make note of your confirmation number. If you do not receive a confirmation number, you have not completed your enrollment and you will not be enrolled in your benefits.

Return to the system anytime and click your confirmation number to view your confirmation statement.

Important Benefit Information

PRE-TAX PREMIUM CONTRIBUTIONS

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This means premiums will be deducted from your gross income. Taxes will then be applied to the remaining payroll amount.

Benefit Allotment

The District covers all of the "Employee Only" cost of the Base PPO Medical, Delta Dental PPO and EyeMed Vision plans. The benefit allotment designated for January 1, 2020 through December 31, 2020 is **$9,245.76**, or **$770.48** per month.

- Unused benefit allocation funds will be distributed over the course of the plan year on each pay date as taxable income.
- If you participate in the Health Savings Account, the District provided H.S.A contribution will be $125 per month which will be deducted from the allotment.

STIPEND IN LIEU OF BENEFITS

The District offers an $1,800 annual stipend to any employee who is eligible for insurance benefits, waives the medical coverage, and can prove they are covered elsewhere under another medical plan. The $1,800 stipend is equally divided by the number of pay dates in the plan year (January 1 to December 31) and the pro-rated amount is included in your paycheck. Employees who become eligible for the stipend at any time during the plan year due to a qualifying event or as a new hire, will receive only the pro-rated amount.

- The stipend will be paid as taxable income
- A signed waiver is required along with proof of coverage

This is an annual election. Your signed waiver and proof of coverage is required every year. The waiver form can be found and printed from the EMB enrollment site.

Send your completed waiver form along with proof of current coverage to the Business Office. A copy of your current medical identification card is acceptable as proof of current coverage.

Dependent Eligibility Audit

In 2014, The School District of Clayton performed an eligibility audit. The audit required all employees who elected to cover their dependents under their employee benefit plans to provide specific documentation showing the dependent's eligibility.

As an ongoing process to identify eligible dependents, all new employee and any current employee who adds dependent coverage will be asked to provide the required documentation. The District will also choose, on a random basis, employee's with current dependent coverage to again show documentation of eligibility.

Sick Leave, Vacation Time, Other Benefits

You can access additional employee benefit information by going to the District's home page and linking to Staff, Human Resources, Employee Resources, Leave Guidelines.

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact the Business Office at extension 6011.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, call the member phone number on your health plan ID card.

COBRA Continuation Rights Under Federal Law

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost of the plan. Please contact the School District of Clayton's Business Office for additional information.

Notice of Privacy Practices

The School District of Clayton is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting the Business Office at extension 6011.

Marketplace Options

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information... When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by the School District of Clayton.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance, which 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, which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2020 through December 15, 2020.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium. Savings 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, which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information... New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Medicaid CHIP Notice

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 will not 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 healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website provided 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 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 askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

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

Medicare Part D Creditable Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

Anthem has determined that the prescription drug coverage offered by the School District of Clayton is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period, which begins on October 15. If you want more information

about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the 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).

Privacy Notice Regarding Wellness Programs

The School District of Clayton may offer wellness initiatives for employees throughout the year. This wellness 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 may 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 may also be asked to complete a biometric screening, which will include a blood test for standard health panels, including lipids and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

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.

Incentives may be available for employees who participate in certain health-related activities. 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. You may request a reasonable accommodation or an alternative standard by contacting the School District of Clayton's Business Office.

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 the School District of Clayton may use aggregate information it collects to design a program based on identified health risks in the workplace, the biometric vendor, H&H, 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 a wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are your EAP provider, PAS, 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 a 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 your Human Resources Department.

Glossary of Terms

Coinsurance – Your share of the cost of covered services, which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out of pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum – The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and co-pays are included in the out of pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

The benefit summary prepared by