PARKWAY SCHOOL DISTRICT

Benefits Guide 2022

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Introduction

Welcome to your 2022 Open Enrollment. Parkway School District offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family during this enrollment period.

Stay Healthy

- Medical/prescription
- Dental
- Vision
- Health Savings Account

Feeling Secure

- Employer paid Long Term Disability
- Flexible Spending Account (FSA)
- Employer paid Life and Accidental Death & Dismemberment
- Voluntary Life and Accidental Death & Dismemberment

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2022 Renewal Highlights

- **Premium Increases** – Depending on which plan you choose there has been a slight premium increase on the medical plans.

- There are no changes in the providers or plan structure for the medical, dental, or vision plans. That means co-pays, deductibles and prescription tiers have remained the same for 4 years.

- **NEW Pharmacy Benefits** – your pharmacy claims manager will move to CVS Caremark. While your copay structure will not change, your mail order pharmacy will and if you receive a specialty medication then your specialty medication coordination will be managed through CVS Caremark.

    - Not restricted to CVS stores for medication
    - Prior Authorizations from ESI will be honored
    - Can bundle medications for pick up

- The FSA administration is through United Healthcare, making the reimbursement process easier and faster. In addition to the debit card, you will be able to submit for reimbursements through an app or online. For more information, please go to the FSA section of the District's benefit site. https://www.parkwayschools.net/Page/2509

- Employees can donate to our four-partner organization during open enrollment through SmartBen. The four organizations that benefit Parkway students and families in our community are Parkway Alumni Association, Parkway Early Learning Foundation, United Way, and Arts & Education Council and Food Pantry.

- The District will continue to contribute a one-time lump sum payment of $520 into the HSA with the first payroll in January and $40 per payroll thereafter for an annual total of $1,440 if you are enrolled in the high deductible plan. You can also contribute to the HSA in addition to the District's contribution. You can change your personal contribution during the year by logging onto SmartBen.

- Employees can sign up for a 403 or 457 plan year round. You can also change your contributions throughout the year. Please visit the benefits page for more information on the plans: https://www.parkwayschools.net/Page/2510

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Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Finance/Benefits.

Plan	Whom To Call	Phone Number	Website
Employee Clinic	CareATC	1-800-993-8244	Careatc.com
Medical (Base and Premium Plan)	United Healthcare	1-866-633-2474	www.myuhc.com
Medical (High Deductible Plan)	United Healthcare	1-866-734-7670	www.myuhc.com
Pharmacy	CVS Caremark	1-844-910-3906	www.caremark.com
Health Savings Account (HSA)	Optum Bank	1-800-791-9361 (Option 1)	www.optumhealthbank.com
Dental Plan (PPO)	Delta Dental	1-800-335-8266 or 1-314-656-3001	www.deltadentalmo.com
Dental Plan (Pre-Paid)	SunLife (Assurant)	1-800-733-7879	www.assurantemployeebenefits.com
Vision Plan	EyeMed	1-866-939-3633	www.eyemedvisioncare.com
Life/AD&D & Voluntary Life/AD&D	Lincoln Financial	1-800-487-1485	www.lfg.com
Long Term Disability	Lincoln Financial	1-800-487-1485	www.lfg.com
Flexible Spending Accounts (FSA)	United Healthcare	1-866-414-1959	www.myuhc.com
Advocate4Me	United Healthcare	Call Number on Back of Medical ID Card	www.myuhc.com
Virtual Visits	United Healthcare	N/A	www.myuhc.com
Employee Assistance Program (EAP)	PAS	1-800-356-0845	www.paseap.com

Benefits Team	Title	Phone Number	Email
Tierra Morris	Benefits Coordinator	1-314-415-8058	tmorris@parkwayschools.net
Brian Whittle	Finance Director	1-314-415-8060	bwhittle@parkwayschools.net
Janet Bova Conti	Benefit Specialist	1-314-415-8059	jbovaconti@parkwayschools.net

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Open Enrollment (How to Enroll)

SmartBen is our online enrollment tool

The site is accessible via the internet at https://sso.smartben.com/SSO/SingleSignOn?partnerIdpName=Parkway%20School%20District and can be accessed 24 hours a day, seven days a week. The following will help you prepare for and complete the online enrollment process. Your open enrollment period for the 2022 calendar year for health benefits is scheduled to begin November 1, 2021 and conclude November 30, 2021. All changes must be received at Parkway by 4:00pm on November 30, 2021.

REQUIRED

ALL EMPLOYEES will need to enroll to make your benefits elections (plan and/or coverage level). If you do not enroll, you may not have your desired level of coverage.

Before you enroll in coverage

Review – take time to review the information in the Plans section. It will help you understand your benefit choices. Discuss it with your family also.

Gather – if you are adding dependents for coverage for next year, gather their information now. You will need to provide the Social Security number and date of birth for any spouse or dependent you enroll. If you have not received the Social Security number for a newborn, enter the numbers 111-11-1111. Contact the Benefits Department to update the dependent's Social Security number after you receive it.

Who is Eligible and When:

Eligible employees are determined by eligibility requirements. Certified staff members are eligible on the first date of employment. All other employees are eligible one month after their start date. Variable hour employees not expected to work 30 hours or more will be measured during their first year of employment and if they average 30 or more hours, will be eligible no later than the first month following their 13-month employment anniversary. Hours worked will be measured annually for December 1 effective date.

How to enroll in coverage

Log on to https://sso.smartben.com/SSO/SingleSignOn?partnerIdpName=Parkway%20School%20District .A direct link for this site is also available on Inside Parkway on the benefits page. Next click "Login: with Parkway School District. "Your Username (pkwy\ then your username) and Password (your District password). This should be the sign-in you use to log into a District computer or Workforce.

Example User Name: pkwy\jdoe3 or pkwy\jsmith

Please use lower case "p" as it is case sensitive. In some browsers or mobile devices, you may need to use your District pkwy.k12.mo.us email instead of the pkwy\ as your username.

Example: ljames@pkwy.k12.mo.us

If you do not have these items, please contact the help desk at 415-8181 or helpdesk@parkwayschools.net.

For full instructions, please visit

Open Enrollment Instructions

Employee Cost:

Your premiums are determined by the plan you select. An **Employee Cost Calculator** is available to help you determine which plan is the best fit for you and your family. This tool can be found on the Parkway School District's website under the ***Benefits Page***. Rate information is also provided while you are reviewing your plan options and making your plan selections in SmartBen.

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Changing Coverage during the Year

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in you or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent termination of you or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Benefits Department within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Benefits Department within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

If you are making a life event change, you must do this through the SmartBen system. You have 30 days from the date of the change in family status to add or change your benefits. You will need to provide documentation of the change. Otherwise, you will need to wait until the next annual open enrollment. Please consult a member of the Parkway Benefits team with any questions.

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Medical Insurance: United Healthcare

Parkway School District's medical insurance is provided by United Healthcare. Visit www.myuhc.com to search for a provider, review the formulary, order additional medical/prescription ID cards, and track your claims and healthcare cost.

The chart below provides an outline of the **In-Network** coverage options available to you. United Healthcare offers you a range of plan options and a support tool to help you determine the plan that best fits your needs and budget.

IN-NETWORK	BASE PLAN	PREMIUM PLAN	HIGH DEDUCTIBLE PLAN
	What you pay	What you pay	What you pay
Physician Visit	$25 Per Visit	$20 Per Visit	Full cost until the $2,800 Deductible is Met. Then 100% covered in Network
Deductible **- Individual** **- Family**	 $650 $1,300	 $500 $1,000	 $2,800 $5,600
Hospitalization	Deductible then 10%	Deductible then 0%	Full cost until the $2,800 Deductible is Met. Then 100% Covered in Network
Preventive Care	100% Covered	100% Covered	100% Covered
Emergency Room	$200 Per Visit	$150 Per Visit	Full cost until the $2,800 Deductible is Met. Then 100% Covered in Network
Out-of-Pocket Max **- Individual** **- Family**	 $2,000 $4,000	 $1,500 $3,000	 $2,800 $5,600
Prescription Drugs **- Generic** **- Preferred** **- Non-Preferred**	**Retail/Mail Order** $12 / $24 $40 / $80 $60 / $120	**Retail/Mail Order** $12 / $24 $35 / $70 $55 / $110	Full cost until the $2,800 Deductible is met. Then 100% covered in Network.
Prescription Drugs Out-of-Pocket Max **- Individual** **- Family**	 $4,500 $9,000	 $4,500 $9,000	 N/A N/A

You receive the highest level of coverage if you receive services from in-network providers. Services received from out of network providers will be processed at a lower benefit level which may result in higher out of pocket expenses to the member. Please refer to the plan benefit summary for out of network benefits.

Please see plan summary for full details

Base Plan Highlights

- This plan has copays when you visit your physician, emergency room, or urgent care.
- The employee cost of this plan is covered by the District. You are responsible for a portion of elected dependent coverage.
- You cannot enroll in a Health Savings Account if you elect this plan. You are eligible for the Flexible Spending Account (FSA).
- Prescription Drug Benefits through CVS Caremark includes a mail order benefit for additional cost savings.
- If you utilize a non-network pharmacy, you are responsible for any difference between what a non-network pharmacy charges and the amount CVS Caremark would have paid for the same prescription drug dispensed from a Network Pharmacy.
- Dependents are covered until 26 (end of month).

Premium Plan Highlights

- This plan has copays when you visit your physician, emergency room, or urgent care.
- You cannot enroll in a Health Savings Account if you elect this plan. You are eligible for the Flexible Spending Account (FSA).
- Prescription Drug Benefits through CVS Caremark includes a mail order benefit for additional cost savings.
- If you utilize a non-network pharmacy, you are responsible for any difference between what a non-network pharmacy charges and the amount CVS Caremark would have paid for the same prescription drug dispensed from a Network Pharmacy.
- The Premium Plan offers a low deductible and out-of-pocket costs as well as lower copayments; however, the premium cost is higher.
- Dependents are covered until 26 (end of month).

Qualified High Deductible Health Plan (QHDHP) Highlights

- If you elect the QHDHP, you may also participate in a Health Savings Account (HSA). Details of the HSA are on the following pages. The District contributes a one-time lump sum payment of $520 into the HSA with the first payroll in January and $40 per payroll thereafter for an annual total of $1,440.
- With an embedded deductible, the health plan begins to make payments as soon as one member of the family has reached the $2,800 deductible limit all of his/her in network claims for the remainder of the calendar year will be covered even through the family deductible of $5,600 has not be met.
- Prescription Drug Benefits are through CVS Caremark.
- The employee cost is covered by District.
- Dependents are covered until 26 (end of month).
- Employees on this plan are eligible for the limited FSA.

Parkway Employee Clinic provided by Care ATC

Employees and their dependents over the age of 2 will have access to the Parkway Employee Clinic. The Clinic provides a multitude of services. Whether you are obtaining an annual physical, or caring for an unexpected illness, these services (and more) can be completed at the Parkway Employee Clinic. If the Clinic physician prescribes a generic medication, you may be able to have it dispensed right at the clinic.

For those on the UHC medical plans, no charges apply for preventive services and for those on the UHC Base or Premium Plans, no copay charged for non-preventive services. If you are on the UHC High Deductible Plan, a $35 office visit will be charged for non-preventive services.

The Parkway Employee Clinic has five locations: Creve Coeur, St. Peters, O'Fallon, Bridgeton, and Claymont in Ballwin. Scheduling an appointment is easy! You have three options: 1) using the CareATC Mobile App, available 24/7; 2) using the website, careatc.com/patients; or 3) calling 800-993-8244. **Click here for more information CareATC**

Employee Pays Per Check- *Please note these rates are for certified staff an employee who work year round and receive 26 paychecks a year. *

Medical Premium						
	Employee Only	Employee & Spouse	Employee & Spouse + 1	Employee & Spouse + 2	Employee & Children (1)	Employee & Children (2)
BASE	$0	$134.77	$200.80	$272.27	$66.00	$134.77
PREMIUM	$66.97	$293.62	$422.61	$523.24	$195.93	$305.05
HSA	$0	$66.63	$128.13	$189.63	$35.88	$76.88

District Pays Per Check

Medical Monthly Premium						
	Employee Only	Employee & Spouse	Employee & Spouse + 1	Employee & Spouse + 2	Employee & Children (1)	Employee & Children (2)
BASE	$353.74	$488.50	$554.53	$626.01	$419.74	$488.50
PREMIUM	$353.74	$488.50	$554.53	$626.01	$419.74	$488.50
HSA	$353.74	$488.50	$554.53	$626.01	$419.74	$488.50

If you work full time but receive less than 26 pays check a year please refer to the link below for rates.

Full Time Employees who recieve less than 26 checks-Per Check

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Wellness Information

The goal of employee wellness at Parkway is simple. We wish to create and maintain a culture of health. We wish to provide a positive, inclusive, holistic wellness program that employees can enter and exit based on their needs and desire. Wellness programs seek to create an environment that increases health awareness, promotes positive lifestyles, decreases the risk of disease, and enhances the quality of life for employees.

Our wellness offerings include help managing chronic conditions like diabetes and high blood pressure, to onsite exercise, to learning about nutrition, to mental wellness support through our employee assistance program.

Our wellness offerings for 2022 Include (but not limited to):

- Naturally Slim-a new online program for mindful eating, weight loss, better sleep, and stress management
- CareATC Employee Clinics providing accessible and great primary care
- Personal Assistance Services, our Employee Assistance Program
- Partnership with local gyms, Community Ed and Fleet Feet Training to provide low cost options for physical activity
- Real Appeal - a weight management program free to members
- Healthy Pregnancy Program
- Flu immunization with CareATC
- Onsite mammography

Please visit our wellness site for more information as well as the complete list of offerings, https://www.parkwayschools.net/Page/3889 .

Or contact Leah Gonzalez, Wellness Coordinator at lgonzalez1@parkwayschools.net or (314) 415-8034.

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Health Savings Account (HSA): Optum Bank

Parkway School District offers a health savings account (HSA) paired alongside your qualified high deductible health plan with United Healthcare. Optum Bank Benefits will continue to be the administrator for the HSA benefit.

An HSA works like an IRA. You deposit money pre-tax and it grows tax-free until you use it. It's your money, no matter what. You can withdraw funds for health insurance costs and medical expenses. And when you reach age 65, you can withdraw it without penalty and use it for whatever you want.

To open an HSA through Optum Bank, you have to be enrolled in a qualified high deductible health plan. You can use the money in the HSA to pay for the health plan's deductible.

How much can you contribute to your HSA in 2022?

- Single: $3,650
- Family: $7,300
- If you are over the age of 55, you can contribute an additional $1,000 each year you are eligible

Parkway School District contributes $1,440 to the HSA each year which lowers the maximum amount you are able to contribute. The federal maximums are $2,210 single / $5,860 family.

Some of the benefits of having a Health Savings Account (HSA) include:

- Stays with you - it's your money even if you change jobs
- Reduces your taxable income – the money is tax-free when you deposit it and when you withdraw it for qualified medical expenses
- Covers other types of bills – pays for insurance deductibles and medical care/supplies not typically covered by medical insurance, vision and dental expenses.
- Use to pay for qualified eligible dependent medical expenses
- Grows with you – the money in the account is yours to invest and the earnings are tax-free.
- Investment Options – Optum Bank offers the ability for consumers to manage their HSA dollars through investments online. By enabling this functionality, your fund balances will be automatically reallocated, consistent with your investment elections, at the frequency you select.

What is the Difference Between a Qualifying 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 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.

Contact Optum Bank to learn more about the benefits of a HSA and to get more information about the administration.

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Flexible Spending Accounts (FSA): United Healthcare

United Healthcare administers the Flexible Spending Account (FSA) benefit. You will receive one debit card for all of our benefits. You will also have the option to request additional care for a spouse or eligible dependent for free. *Please note

Benefits You Receive
FSA provides you with an important tax advantage that can help you pay for essential health care expense that are not covered, or are partially covered, by the medical, dental and vision insurance plans. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA
This program lets Parkway School District employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the Health Care FSA is $2,750*. You have until March 15th to claim the funds from the previous plan year.

Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture

Limited Purpose FSA
If you participate in a HSA you may have a Limited Purpose Health Care FSA. The annual maximum amount you may contribute to the Limited Purpose FSA is $2,750*. You have until March 15th to claim the funds from the previous plan year. The eligible expenses are limited to:

- Dental expenses
- Vision expenses

Dependent Care FSA
The Dependent Care FSA lets Districts employees use pre-tax dollars towards qualified dependent care such as caring for children under age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000* (or $2,500* if married and filing separately) per calendar year. Some examples of eligible expenses include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

* **These are 2021 figures, as the IRS has not finalized them. If they change and you select the maximum, the benefits department will contact you.**

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Dental Care: Delta Dental

The dental benefit is offered through Delta Dental.

Who is Eligible and When:

Full time employees working at least 30 hours per week are eligible. Teachers and Administrators are eligible date of hire. Operations Staff are eligible 30 days following date of hire.

Employee Pays Per Check

Dental Premium				
Coverage Level	**Employee Only**	**Employee & Spouse**	**Employee & Spouse & 1 or more Child(ren)**	**Employee & 1+ Child**
DEDUCTION PER CHECK	$0	$8.99	$22.89	$13.90

The chart below provides an outline of the coverage you receive when you use in-network providers. You receive the highest level of coverage if you receive services from in-network providers. Services received from out of network providers will be processed at a lower benefit level which most likely will result in higher out of pocket expenses to the member.

The network attached to the plan is the Delta Dental PPO/Premier. To search the network for participating providers please visit www.deltadentalmo.com

Type of Service	PPO Network	Premier Network	Non-Network
Annual Maximum	$1,250 Per Person		
Deductible	$50 Individual / $150 Family		
Preventive Care	0%	0%	0%
Basic Services	20%	25%	25%
Major Services	40%	45%	45%
Orthodontia	Lifetime Maximum of $1,000 40%, Adults and Child (ren) to the age of 26.		

Dental Care: Assurant – now known as SunLife

Who is Eligible and When:

This dental option is closed to new enrollees. This is a grandfathered plan for existing employees. The Assurant Dental plan offers a copay type plan for in network services only.

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Vision Plan: EyeMed

The vision benefit is offered through EyeMed.

Who is Eligible and When:
Full time employees working at least 30 hours per week are eligible. Teachers and Administrators are eligible date of hire and Operations Staff are eligible 30 days following date of hire.

Below provides an outline of the coverage you receive when you use in-network providers. You receive the highest level of coverage if you receive services from in-network providers. Services received from out of network providers will be processed at a lower benefit level which most likely will result in higher out of pocket expenses to the member. The network attached to the plan is the EyeMed Insight network.

Voluntary Vision

Well Vision – Every 12 months, $0 copay

Prescription Lenses
$20 copay

Lenses – Every 12 months

- Single vision, lined bifocal, and lined trifocal lenses
- Polycarbonate lenses for dependent children

Frames – Every 24 months

- $130.00 allowance for a wide selection of frames
- 20% off the amount over your allowance

OR Contacts (instead of glasses) – Every 12 months

- Up to $55 copay for your contact lens exam (fitting and evaluation)
- $130 allowance for contacts

Employee Pays Per Check

Vision Premium			
Coverage Level	**Employee Only**	**Employee & 1 Dependent**	**Employee & Family**
	$0	$1.07	$2.06

Out-of-Network Services

You can choose to receive care outside of the EyeMed Vision network. You simply get an allowance toward services and you pay the difference. In-Network benefits and discounts will not apply. Just pay in full at the time of service and then file a claim for reimbursement.

As an EyeMed member, you can get any frame for $0 out-of-pocket when you shop at Sears Optical or Target Optional – even top fashions brands are included!! Please use offer code 755284 to take advantage of this offer.

How to find a provider

- Click “Find a Provider” at the top right of the webpage.
- Enter your zip code, select the *Insight* Network and hit the “Get Results” button.
- The search will generate a report of the search results, listing the providers closest to your zip code first.
- You can refine your search even more under the “Filter Search Results” on the left side of the webpage.
- Or, you can call 1-866-939-3633 to speak with a Customer Service Representative.

You can also use this website for practical tools and personalized information for your vision care.

- Learn about vision wellness to manage your vision health and wellbeing.
- Check your in-network vision benefits and how to use them.

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Disability Insurance: Lincoln Financial
Long Term Disability (LTD)

The LTD benefit is provided by Lincoln Financial.

Who is Eligible and When
Full time operations staff and administrators working at least 30 hours per week are eligible 30 days following their date of hire.

Employee Pays: This is an employer paid benefit so there is no cost to the employee.

Employer Pays: The entire cost of the benefit is paid for by Parkway School District

What is Long Term Disability insurance?
When an employee cannot work for an extended period of time due to a disability, a long term disability plan can help cover a portion of the employee's salary.

Why is Long Term Disability insurance important?
Statistics show 3 out of every 10 workers between the ages of 25 and 65 will experience an accident or illness that keeps them out of work for 3 months or longer, with nearly 60% of these injuries occurring off the job. If an employee is hurt off the job, worker's compensation will not cover them.

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Life and AD&D Insurance: Lincoln Financial

The Life and Accidental Death and Dismemberment (AD&D) benefit is provided by Lincoln Financial. Parkway offers Basic Life and AD&D at no cost to you and provides you with the opportunity to purchase additional coverage on a voluntary basis.

Who is Eligible and When

Basic Life and AD&D: Full time teachers and administrators working at least 30 hours per week are eligible their date of hire. Full time Operations Staff working at least 30 hours per week are eligible 30 days following their date of hire.

Voluntary Life and AD&D: Full time teachers, administrators working at least 30 hours per week and their dependents are eligible their date of hire. Full time Operations Staff working at least 30 hours per week and their dependents are eligible 30 days following their date of hire.

Basic Life and AD&D Insurance

Parkway provides eligible full-time employees with group Life and AD&D insurance and pays the full cost of this benefit.

Voluntary Life and AD&D Insurance

Voluntary Life and Accidental Death and Dismemberment insurance offers protection from Life's unforeseen events – giving you and your family assets to help ensure that immediate expenses, as well as long-term obligations, can still be met.

Employees who want to supplement their group Life and AD&D insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents, in this benefit, you pay the full cost through payroll deductions. Voluntary Life and voluntary AD&D are elected separately.

<u>You must purchase supplemental life/AD&D on yourself in order to purchase coverage for your spouse and/or dependent children.</u> Benefit reductions apply upon attaining certain age levels. Most employees have coverage available in the amounts of $25,000, $50,000, $100,000, $150,000 or $200,000. The guarantee issue for most employees is $200,000. Spousal coverage is available in the amounts of $10,000, $15,000, $25,000 or $50,000. The guarantee issue for the spouse is $$50,000. Child(ren) coverage is available from live birth to 26 years of age and your choice is $5,000 or $10,000.

Important Note: This is not an enrollment period for this benefit. If you and/or your dependents did not enroll during last year's initial enrollment period in the Voluntary Term Life and AD&D plan you will be required to complete an Evidence of Insurability (EOI) from and be approved by Lincoln Financial before you are able to obtain coverage.

Voluntary Life

The Monthly Voluntary Life and Accidental Death and Dismemberment insurance rates are less this year than last year! See the rate chart below for rates per $1,000 of coverage.

Monthly Rates Per $1,000 of Employee, Spouse and Child Vol Life Insurance Coverage						
Age	<25	25-29	30-34	35-39	40-44	45-49
Vol Life	$0.050	$0.050	$0.050	$0.070	$0.120	$0.180
Age	50-54	55-59	60-64	65-69	70-74	75+
Vol Life	$0.280	$0.440	$0.670	$1.060	$1.620	$2.820
Spouse Life	Same rates as above, based on Employee age					
Dependent Life	$0.90 / $0.180					

Please Note:

The information in this Benefits Guide is for illustrative purposes only and is based on information taken from all insurance carriers summary plan descriptions and benefit summaries. Every effort was taken to accurately report your benefits, however, discrepancies and errors may occur. If there is a discrepancy between this Benefits Guide and the Summary Plan Description or Carrier Benefit Summary, the actual plan documents from the insurance company will prevail. If you have any questions, please direct them to your Human Resources Department.

Parkway School District reserves the right to amend, modify or terminate these plans at any time as allowed by law. Your participation in these plans does not guarantee your employment at the company and does not create a contract of employment, express or implied.

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Employee Assistance Program (EAP)

Parkway offers an Employee Assistance Program at no cost to our employees. This benefit is through PAS and offers confidential, short-term counseling for personal and family issues.

Our employee assistance program is designed to save you time and stress. The program can give you a way to cope with personal issues or work-related stress. PAS provides an extensive suite of counseling and life coaching services to help you navigate challenges, and improve your quality of life – emotionally, physically, financially, personally, and professionally.

Program Features

Work Life Services	Will Preparation
Legal and Financial Counseling	Legal Document Preparation
Identity Theft	Funeral Preparation
Tax Consultation	Bereavement/Daily Living Resource
Healthy Eating	Life Coaching
Employee Discounts	Tobacco Cessation
Child and Elder Care Consultation	Chronic Medical Condition Management

Remember, your communications with the EAP are always confidential.

First-Time Users:

1. Go to www.paseap.com and click on “Register”.
2. Provide your organization web ID: PARKWAYSD and wayForward app code PARKWAYSD
3. Create a user name and password.

Future Logins:

Simply enter your user name and password, and then click on the “Login” button. If you have problems registering or logging in, call 1-888-327-9573.

Employee Assistance Program

Your Resource for Life's Questions

Each of us experiences demands for our time and energy, both on and off the job. In addition to our responsibilities at work, we also seek to fulfill our family responsibilities, meet our financial obligations, enjoy personal interests, and maintain a healthy family and social life. The key to balancing it all is having access to the right tools, resources and support.

Personal Assistance Services (PAS) provides you with a wealth of confidential, professional services that can help you address challenges and strengthen your work and home life.

This is a pre-paid benefit funded completely by your employer and free to you and your dependents. The EAP is confidential - PAS does not disclose information to anyone about your participation unless you give your consent to do so (except as required by law).

Through PAS you have access to:

- Elder care managers
- Child care specialists
- Certified child development and parenting professional
- Organization and time management specialists
- Retirement coaches
- Career coaches
- Tobacco cessation coaches
- Master's level licensed counselors
- Registered and licensed dietitians
- Certified financial counselors
- Attorneys
- Life coaches
- Health coaches
- Self-paced cognitive behavioral therapy through the wayForward digital app
- Downloadable resources, financial tools, legal forms and more on the PAS website

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Additional Health Benefits and Parkway Employee Clinic

Get the Most from Your Benefits

Parkway School District offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. If you have any questions, please contact the Parkway Benefits Department.

To get the most from your benefits during the year, try these tips:

- Ask your doctor for the generic equivalent of the brand-name drug prescribed
- Visit in-network providers for your care

Find Care and Cost tool

Quickly and easily estimate your health care costs on www.myuhc.com. A mobile version of the Find Care and Cost tool is available in the Health4Me mobile app.

Using your benefit information, myHealthcare Cost Estimator:

- Shows you the estimated costs for a treatment or procedure
- Displays how that cost is impacted by your deductible, co-insurance and out-of-pocket maximum
- Gives you an estimate of what you'll be responsible to pay
- Provides you with usable information for planning and budgeting

You can use this information to Plan your care and Save money, Budget for medical expense, Find doctors that better meet your needs, or Learn about new treatment options

Rally

Rally is a user-friendly digital experience on www.myuhc.com that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey. With the online Rally Health Survey, personalized missions, rewards and connections to wearables like Fitbits, Jawbones and more, it is easier for you to get motived to be healthier.

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.

Conditions commonly Treated Through a Virtual Visit

Bladder Infections/Urinary Tract Infection	Pink Eye	Rash
Bronchitis	Fever	Sinus Problems
Cold/Flu	Migraine/Headaches	Sore Throat

To Access, Login to www.myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay for your United Healthcare Plan.

Wondr Health (formally Naturally Slim)

Naturally Slim (NS) is digital behavior change program that will help you build lifelong skills for less stress, better sleep, and weight loss that sticks – no restrictive diets, calorie-counting, or specialty foods required. With the NS program, you'll learn to change *when* and *how* you eat, not *what* you eat, so you can improve your physical and mental health without giving up the foods you love. The program is offered at **no additional cost** to all Parkway Schools employees, spouses/domestic partners and adult dependents 18 and older who are members of our United Healthcare plan. Participation in Naturally Slim is confidential and information will not be shared with Parkway School District. You can participate in NS wherever and whenever you want on your phone, computer, or through the NS mobile app.

This program is not available if you are Medicare Eligible.

The Wondr Health program includes:

- Personalized video curriculum to help you meet your goals
- Digital dashboard for learning, goal setting, tracking, and more
- Motivation in the form of regular emails and texts to keep you motivated and on track
- Health coaches to help you work through specific challenges
- Mobile app for easy access to NS matter where you are
- Online community for social support
- Online tools to give you feedback, provide accountability, and build skills
- Digital integration with activity trackers, scales, and digital assistants like Amazon Alexa

To learn more and apply, go to Wondr Health.

What to Expect

Currently there is a waitlist, the next enrollment will be in January 2022. More details will be sent at that time via email.

Advocate4Me

Advocate4Me is a consumer engagement program that provides United Healthcare members with a single point of contact to address your various health needs. By calling a single toll-free number, listed on the back of your ID card, or using your preferred communication channel, members are connected with an Advocate who provides them with end-to-end support, "owning" their request unit it's resolved. This service is offered at no charge to United Healthcare members.

Real Appeal

Real Appeal is a weight loss and healthy lifestyle program, available to eligible Parkway School District employees and their dependents as part of our United Healthcare benefit plan. It is a simple, step-by-step program designed to introduce small changes over time that lead to healthier habits and long lasting weight loss results. The program is offered at **no additional cost** to employees, spouses/domestic partners and dependents 18 and older who are members of our United Healthcare plan **with a BMI (body mass index) of 23 or higher**. Your BMI will be calculated during a personalization session to confirm that you qualify for the program. Participation in Real Appeal is confidential and information will not be shared with Parkway School District. This is a great opportunity to take charge of your personal health or team up with a loved one to lose weight and learn some healthy new habits.

This program is not available if you are Medicare Eligible.

To Get Started, Go to parkway.realappeal.com

The Real Appeal program comes complete with a number of complimentary tools and resources including:

- **A personal Transformation Coach**, who will provide guidance and support throughout the program and assist in tailoring a simple approach customized just for you.
- **A Success Kit**, shipped right to your door and containing step-by-step guides, workout DVDs and equipment, healthy recipes, kitchen tools including a personal blender and more (see the attached document to see what all is included in the kit)
- **The Real Appeal Website and Mobile App** to help you stay inspired and keep you accountable to your goals by giving you access to 24/7 support and tracking tools. The app is available in both the Apple App store and Google Play.

Sign up now using a smartphone, tablet or personal computer to get started or grab a loved one and sign up together!

Livongo

Livongo health benefit is offered at **no cost** to eligible members enrolled in the medical plan. The Livongo for Diabetes and Livongo for Hypertension programs make living with diabetes and high blood pressure easier!

The Diabetes program is for members diagnosed with Type 1 or Type 2 diabetes. A wireless connected meter uploads readings and provides real-time tips. Test strips and lancets are shipped to your home, free of charge. Certified Diabetic Educators assist you with nutrition and lifestyle changes.

The Hypertension program includes a remote monitoring wireless blood pressure cuff which tracks progress and provides tips to help you stay on track. Licenses professionals provide live coaching, virtual care, and 24/7 digital alerts.

Care Options and When to Use Them

Parkway Employee Clinic

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 the Parkway Employee Clinic or a Convenience Care Center – they can be an alternative to seeing your doctor.

The Parkway Employee Clinic has five locations: Creve Coeur, St. Peters, O'Fallon, Bridgeton and Claymont in Ballwin. Scheduling an appointment is easy! You have three options: 1) using the CareATC Mobile App, available 24/7; 2) using the website, careatc.com/patients; or 3) calling 800-993-8244. For more information, visit the Parkway Cares site link: https://www.careatc.com/parkwaycares

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-Mart and Target, 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 our website at www.myuhc.com.

Typical Conditions that may be treated at a Convenience Care Center include….

- Common Infections (bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor Skin Conditions (athlete's foot, cold sores, minor sunburns, poison ivy)
- Flu Shots
- Pregnancy Tests

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.

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 the carrier's website at www.myuhc.com.

Typical Conditions that may be treated at a Convenience Care Center include….

Sprains	Strains	Small Cuts	Sore Throats	Mild Asthma Attacks
Rashes	Minor Infections	Vaccinations	Preventive Screenings	Back Pain or Strains

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. Emergency services are always considered at the in-network benefit level.

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 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 parts

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.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once the condition has been stabilized.

Please Note: you may incur out-of-network expenses if you receive services from an out-of-network Emergency Room physician, pathologist, radiologist or anesthesiologist, even if the hospital is in-network.

Some examples of emergency conditions may include the following…..

Heavy bleeding	Chest Pains	Large Open Wounds	Sudden Change in Vision
Spinal Injuries	Difficulty Breathing	Major Burns	Sudden Weakness
Trouble Walking	Severe Head Injuries		

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 of money out-of-pocket when you receive care in your doctor's office.

Lab Services

If you require routine lab work, consider having these services performed at LabCorp. In most cases, the cost of your lab services will be covered at 100% if coded as preventive. Beginning on 1/1/19, Quest Diagnostics has joined United Healthcare as an in-network provider. So now you have two choices when you have to have routine lab work.

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COBRA Continuation Options

Selecting the right health care coverage option is important when facing an employment transition. We know how complex healthcare coverage can be, especially with the recent introduction of the Affordable Care Act.

The Affordable Care Act did not eliminate COBRA or change the COBRA rules. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. This also applies to spouses and /or dependents currently enrolled on the Parkway plan.

The question then becomes whether or not taking COBRA is a better choice than purchasing a new policy through an insurance exchange and applying for a federal subsidy if eligible.

- **COBRA coverage may be more expensive than a new individual policy through the health insurance exchange.**

  This is because if a COBRA policy is continued, the employee has to pay both their share of the premium and the employer's contribution. If the policy is rich with benefits and the employer has been paying a significant portion of the premium, chances are the full premium will be higher than other health insurance coverage options through the health exchanges.

- **Rather than take COBRA, the Affordable Care Act provisions all low-income individuals to get coverage at a lower cost because of their potential eligibility for federal subsidies.**

  These subsidies are designed for people who earn between 100 percent and 400 percent of the Federal Poverty Line, or about $26,500 - $106,000 for a family of four or $12,880 - $51,520 for an individual. If an employee's income is under these limits, it will probably be more cost effective to purchase a new policy and receive the subsidies to help pay the premium.

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Important Notices and Reminders

Health Insurance Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

For Employers Who Offer a Health Plan to Some or All Employees

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

4. Employer name Parkway Schools	5. Employer Identification Number (EIN) 43-6000857	
6. Employer address 455 North Woods Mill Rd	6. Employer phone number 314-415-8100	
7. City Chesterfield	8. State MO	9. ZIP code 63017
10. Who can we contact about employee health coverage at this job? Brian Whittle		
11. Phone number 314-415-8060	12. Email address bwhittle@parkwayschools.net	

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

- As your employer, we offer a health plan to:

☑ Some employees. Eligible employees are:
Employees working 30+ hours per week

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are: Domestic Partners, Spouses and Dependent Children. Eligible dependents are covered to age 26.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Mental Health Parity and Addiction Equity Act Disclosure

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Company Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at **(314) 415-8100**.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at **(314) 415-8100**.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **(314) 415-8100** for more information.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact
Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

IMPORTANT NOTICE FROM PARKWAY SCHOOL DISTRICT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D

CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your company 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. Your company has determined that the prescription drug coverage offered by the Company 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 Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your company 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 call your benefit administrator. 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 your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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 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).

Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

General Notice of COBRA Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Francis Howell School District Benefits Office
4545 Central School Road
St. Charles, MO 63304
(636) 851-6099

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Plan contact information
Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact
Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from this plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact
Parkway School District
Brian Whittle
455 North Woods Mill Road
Chesterfield, MO 63017
bwhittle@parkwayschools.net

General FMLA Notice

Employee Rights Under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243)

TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

USERRA Notice *Your Rights Under USERRA*

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in **some cases, a comparable job.**

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

Then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Initial (General) COBRA Rights Notice

- Notice informs of the right to COBRA when coverage is lost due to a qualifying event
- Must be provided within **90 days** of coverage
- May be provided separately in new hire packets, in enrollment materials, or in a packet of legal notices
- Must be provided to employees and spouses covered by the plan
  - Due to the spousal notice requirement, this should technically also be mailed to the home address
- The SPD also includes COBRA rights information, but the contents usually differ from this notice and the SPD may not always meet this notice's timing requirement

Grandfathered Status Notice

- This notice discloses that a plan is grandfathered under the ACA and is not required to comply with certain ACA mandates
- The notice is required to maintain grandfathered status
- Must be provided in all written materials describing the plan, including:
  - SPD
  - Enrollment Materials

ACA Section 1557 Nondiscrimination Notice

- Notice is required of covered entities which are generally:
  - Healthcare providers, or
  - Group health plans that receive federal funding from HHS (many plans "voluntarily" complied with or without their knowledge due to pressure from insurance carriers and third party administrators)
- Notice informs participants that the plan may not refuse to treat or otherwise discriminate due to race, color, national origin, sex, age, or disability
- Must be provided **annually** and include information about the availability of assistance in other languages
- This notice can be wholly satisfied by the SPD

Note: The U.S. Department of Health and Human Services issued final regulations eliminating this notice requirement as of **August 18, 2020**.

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, but do apply towards your out of pocket maximum. 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.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

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.

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 any 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.