2025 Benefits Guide

Your Health & Wellness

Retiree / COBRA / LOA / Surviving Dependents
MEDICARE & NON MEDICARE ELIGIBLE

PARKWAY SCHOOLS

Contents

The information in this Enrollment Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage, and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any express or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact Human Resources.

Welcome to Your 2025 Benefits!

Parkway School District is pleased to provide you and your family with a wide range of competitive benefits. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed.

Highlights:

No changes in Dental and Vision premiums!

Check out changes to the medical plans on page 7

Pharmacy transitioning to Express Scripts

Continued access to CareATC

Please visit the benefits and wellness site for great resources including mental health

www.parkwayschools.net/Page/13976

Open Enrollment

The open enrollment period for the 2025 calendar year for health benefits is scheduled to begin November 1, 2024 and conclude November 30, 2024. All changes must be received at Parkway by 4:00 pm (CST) on November 30, 2024. Any changes made during Open Enrollment will take effect on January 1, 2025.

Join us for an informative session to discuss the changes to your benefits plan for the 2025 plan year. Representatives from our insurance carriers and CareATC will be available to answer your questions. Marsh McLennan Agency, our insurance broker, will also be in attendance to answer questions and assist with your options on Medicare.

IN PERSON & VIRTUAL MEETING

Wednesday, October 30th, 4:00 – 5:00 pm

Welcome Center at South Middle School

760 Woods Mill Rd.

Manchester, MO 63011

Call in information below, or you can attend IN PERSON

Meeting Link:	meet.google.com/bnq-ayhy-inj
Join by telephone	+1 402-249-0967
PIN:	590 188 265#

If you are a recent retiree, (retired within the past year), you are only allowed by state law to add a dependent to your coverage within the first year of your retirement. For example, if you retired June 30, 2024, you have until June 30, 2025 to add a spouse or dependent child. During this first year of retirement, you may add your dependent at any time, not just during open enrollment. Should you have any questions regarding your insurance coverage, please feel free to contact our Benefits Department at (314) 415-8059 or email benefits@parkwayschools.net.

If you or your spouse will be turning 65 during this 2025 benefit period, please make sure you sign up for Medicare part A and B three months prior to your birthday. For an information packet and enrollment form for Anthem Blue Cross/Blue Shield Medicare Advantage Plan or the Aetna Advantage Plan, please contact the benefits department at (314) 415-8059.

Changing Coverage During the Year

Changing Benefits After Open Enrollment

During the year, you cannot make changes to your medical, dental, or vision plans, unless you experience a Qualified Life Event, such as Marriage, Divorce, Spouse lost coverage, etc. If you experience a Qualified Life Event (examples below), you must contact the Parkway Benefits Department. A written notice (an email will suffice) needs to be received within 30 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

NOTE: You can cancel any of your benefits during the year. We drop on the last day of each month. Please email the Benefits Department if you want to drop any of your benefits. Email: benefits@parkwayschools.net.

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Medical – United Healthcare

Parkway School District's medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each month and when you need care.

The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** —a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 10% for services and the plan pays 90% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Before You Enroll

Consider this:

1. Think about the monthly cost and out-of-pocket expenses you will incur and your possible future medical expenses.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting the myuhc.com. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

UNITED HEALTHCARE	BASE PLAN	PREMIUM PLAN	HIGH DEDUCTIBLE PLAN (HSA)
	Choice Plus	Choice Plus	Choice Plus
	In-Network	In-Network	In-Network
Calendar Year Deductible			
Individual	$650	$500	$3,400
Family	$1,300	$1,000	$6,400
Calendar Year Out-of-Pocket Maximum (Includes Deductible)			
Individual	$3,000	$1,500	$3,400
Family	$6,000	$3,000	$6,400
	You pay	You pay	You pay
Coinsurance	10%	0%	0%
Preventive Care	No Charge	No Charge	No Charge
Primary Care Physician	$25	$20	Deductible
Specialist	$50	$30	Deductible
Urgent Care	$75	$50	Deductible
Emergency Room	$200	$150	Deductible
Lab & X-ray	Deductible then 10%	Deductible	Deductible
Hospitalization	Deductible then 10%	Deductible	Deductible
Diagnostic Imaging (MRI/CT)	Deductible then 10%	Deductible	Deductible
Pharmacy			
Rx Deductible	N/A	N/A	Medical Deductible Applies
Rx Out-of-Pocket Max Individual Family	 $3,000 $6,000	 $1,500 $3,000	 N/A N/A
Retail Rx (up to 30-day supply)			
Tier 1	$12	$12	Full cost until the $3,400 Deductible is met; then 100% covered in Network
Tier 2	$40	$35	
Tier 3	$60	$55	
Mail Order Rx (90-day supply)	$24 / $80 / $120	$24 / $70 / $110	

UHC ONLY Medical Monthly Premiums:

	RETIREES & COBRA/LOA		
	BASE PLAN	PREMIUM PLAN	HIGH DEDUCTIBLE PLAN (HSA)
Retiree Only	$759.99	$906.42	$629.22
Retiree & Spouse	$1,324.45	$1,666.53	$1,054.67
Retiree & Spouse + 1 Child	$1,601.01	$2,075.96	$1,321.99
Retiree & Spouse & 2+ Children	$1,900.38	$2,438.74	$1,601.03
Retiree & 1 Child	$1,036.43	$1,315.72	$844.22
Retiree & 2+ Children	$1,324.45	$1,690.10	$1,075.58

PAY $0 FOR SELECT SPECIALTY MEDICATIONS

Participate in the SaveOnSP program

Specialty medications can cost a lot of money. That's why your plan offers a program called SaveOnSP, to lower your out-of-pocket costs to $0.

Participate in SaveOnSP and save.

Over 300 specialty medications are eligible for the SaveOnSP program.[1] If you're filling an eligible medication, a representative from SaveOnSP will contact you to discuss the program.

You'll pay $0 for your medication when you participate in SaveOnSP. If you choose not to participate, you'll pay a higher cost share when you fill your medication.

Conditions covered by SaveOnSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis
- Cancer

Here's an example of how it works.[2]

John's taking a specialty medication that's eligible for the SaveOnSP program. His copay is currently $70. His new cost share will be $1,150.

- **When he participates in SaveOnSP, he won't pay anything ($0) out-of-pocket.** He will work with SaveOnSP to enroll with the applicable manufacturer copay assistance program.
- **If he decides not to participate in SaveOnSP, he'll pay his full cost share of $1,150 out-of-pocket.**

In both of these examples, John's cost share wouldn't count toward his deductible or out-of-pocket maximum.

1. The drug classes and medications in this program are subject to change. Check your plan materials to see which medications are eligible for the SaveOnSP program.
2. For illustrative purposes only. Plans may vary.

EXPRESS SCRIPTS® SaveOnSP

EVERNORTH HEALTH SERVICES

omada

Add healthy habits to medication for lasting results

EncircleRx℠ and Omada Health

What

Enroll and engage in Omada to get your medication* covered, if clinically eligible.

+ Omada is a virtual health program that helps members create healthier habits to achieve long-lasting results
+ Omada is $0 cost to you
+ Filling your medication requires prior authorization from your doctor to confirm eligibility criteria is met

Why

Omada will help you on your journey by complementing the impact of your medication.

+ Support from a personal health coach
+ Easy monitoring with smart devices (you keep)
+ Motivation from a peer group and online communities
+ Tools to guide and support you with achieving long-term goals

How

You will need to participate in the Omada program meeting the following requirements each month:

+ Engage four times on the smart device provided by Omada
+ Use the Omada app four times, by doing lessons or engaging with your health coach, peer group or online community

CRP1224504A

Enroll today!

Register or log in to esrx.com/healthsolutions to get your access code

Then sign up at omadahealth.com/esi or download the Omada mobile application

For more information, contact your Express Scripts representative

*Omada is available at no additional cost to you. Your health plan benefits may require you to pay out-of-pocket costs for your medication and meet additional requirements for medication coverage.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a personal savings account that you own and can use to pay for qualified out-of-pocket medical expenses. Your HSA can be used to pay for your health care expenses and those of your spouse and dependents, even if they are not covered by the High Deductible Health Plan (HDHP). If you had the HSA while you were an employee, then you can continue contributing to Optum Bank directly on your own. Go to myuhc.com for further information on how to contribute. If you are a Retiree and switching over to the High Deductible Account, you will need to go to any bank and set up an HSA (Health Savings Account) with that bank.

What happens to your HSA Once you enroll in Medicare?

This is the important thing to remember about your HSA when enrolling in Medicare: **once you enroll in any part of Medicare, you're no longer eligible to make HSA contributions.** This includes Medicare Part A or Medicare Part B – either one will prevent you from contributing further to your HSA. Many people turning 65 who continue to work may consider getting Medicare Part A since it's premium-free. But, as stated, once you enroll in Part A, you can't make any more pre-tax contributions to your HSA. If you plan to keep working and want to continue building your HSA up, check to see if you're eligible to delay Medicare enrollment. If you're receiving Social Security benefits however, Medicare Part A is mandatory.

What to do with your HSA if you get Medicare Part A

If you have to (or choose to) enroll in Medicare Part A, the coverage is retroactive for up to 6 months, but no earlier than your eligibility date. Because of this, you should plan to stop HSA contributions around 6 months before enrolling in Medical. You can contribute to your HSA for the months that you were eligible for Medicare and were not yet enrolled.

The good news: You can keep using your HSA funds

Now for the good news! Even after you enroll in Medicare and stop HSA contributions, you are still able to withdraw funds tax-free for qualified medical expenses. You can even use your HSA to pay for some Medicare expenses including your Medicare Part B, Part D and Medicare Advantage plan premiums, deductibles, copays and coinsurance. Note: HSA funds cannot be used to pay for Medigap premiums.

How an HSA Account Works

Eligibility
Anyone who is:
- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not a High Deducible Health Plan (HDHP);
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return

Your Contributions
You can contribute up to the IRS maximum of $4,300/individual or $8,550/family.
You can make an additional "catch-up" contribution of up to $1,000 per year if you are age 55 or older.

Eligible Expenses
You can use your HSA to pay for medical, dental, vision and prescription drug expenses incurred by you and your eligible family members. *Please note: Funds available for reimbursement are limited to the balance in your HSA.*

Using Your Account
Use the debit card linked to your HSA to cover eligible expenses — or pay for expenses out of your own pocket and save your HSA dollars for future health care expenses.

Your HSA is always yours – no matter what
One of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it the following year or at any time in the future.

The Triple Tax Advantage

HSAs offer three significant tax advantages:

1. You can use your HSA funds to cover qualified medical expenses, including dental and vision expenses — tax-free.
2. Unused funds grow and can earn interest over time — tax-free.
3. You can save your HSA dollars to use for your health care when you leave Parkway Schools or retire — tax-free.

If you want to save tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Year 1 Example: You enroll in the HDHP with HSA during enrollment		Year 2 Example: You enroll in the HDHP plan again next year
You contribute $4,300 for a total of $4,300		$3,600 rolls over from last year and you contribute $4,300 for a total of $7,900
You use the HSA to pay $700 of eligible expenses		You use the HSA to pay $1,250 of eligible expenses
You have $3,600 in the HSA to roll over to next year!		**You have $6,650 in the HSA to roll over to next year!**

Dental

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures. Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

Parkway School District offers dental coverage through Delta Dental. For information on finding a dental provider, visit deltadentalmo.com and click on Find a Provider.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care with Delta Dental in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

Grandfathered Dental Care: SunLife – formerly known as Assurant

Who is Eligible and When:

This dental option is closed to new enrollees. This is a grandfathered plan for existing employees. The SunLife Dental plan offers a copay type plan for in network services only. The premium rates are not changing for 2025.

Dental Care: Delta Dental of Missouri

The table below summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions. The network attached to the plan is the Delta Dental PPO/Premier. To search the network, visit deltadentalmo.com.

	Delta Dental of Missouri	
	PPO	
	In-Network	Premier/Out-of-Network
Individual Deductible	$50	$50
Family Deductible	$150	$150
Per Individual Annual Maximum	$1,250 Per Person	
	You pay	
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments (< Age 19), Sealants, Space Maintainers (< Age 16)	0%	0%
Basic Services		
Fillings, Extractions,, Endodontics	20%	25%
Major Services		
Crowns, Inlays/Outlays, Dentures and Bridgework, Oral Surgery, Periodontics	40%	45%
Orthodontia		
Adults	40%; $1,500 Lifetime Maximum	
Children (up to 26th birthday)		

Dental Monthly Premium – *NO rate increase in 2025:*	
	RETIREES & COBRA/LOA
Retiree Only	$50.32
Retiree & Spouse	$88.08
Retiree & Spouse & 1+ Child(ren)	$146.58
Retiree & 1+ Child(ren)	$108.76

Once enrolled, if you have lost your Delta Dental ID card, please call Delta Dental at 314-656-3001 to request a new ID card. Parkway's Group Number is 15271000.

Dental Care:
Assurant – now known as SunLife Dental DHMO

This dental benefit is offered through SunLife. **Not open to new enrollees**. Only those already on this plan can continue on this plan. This dental plan is in-network only. Services received from out of network providers will not be covered under this Assurant copay plan.

	SunLife Dental Heritage Series
	DHMO Network Providers
	Basic Plan #903221
Individual Deductible	$0
Family Deductible	$0
Annual Maximum	NA
	You pay
Preventive Care	Scheduled Copayment
Basic Services	Scheduled Copayment
Major Services	Scheduled Copayment
Orthodontia	Discounts Available
Dental Monthly Premium – *NO rate increase in 2025*	
Retiree Only	$14.55
Retiree + 1 Dependent (Dependent is defined as a spouse or child)	$23.45
Retiree + 2+ Dependents (Dependent is defined as a spouse or child)	$35.91

Vision Plan: EyeMed Vision Care

Parkway School District continues to offer vision coverage through EyeMed. Healthy eyes and clear vision are an important part of your overall health and quality of life.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

For information on finding a vision provider, visit member.eyemedvisioncare.com/member and click on Find a Provider. The network attached to the plan is the EyeMed Insight Network.

If you have lost your EyeMed Vision ID card, please call EyeMed Vision at 1-866-800-5457 to request a new ID card. Parkway's Group Number is 1006768 Insight Network.

Vision Monthly Premium (RETIREES & COBRA/LOA) – *NO rate increase in 2025:*	
Retiree Only	$5.38
Retiree + 1 Dependent	$9.64
Retiree + 2+ Dependents	$13.62

Parkway School District

40% OFF
additional complete pair of prescription eyeglasses

20% FF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$0 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal	$20 copay	Up to $65
Lenticular	$20 copay	Up to $65
Progressive - Standard	$85 copay	Up to $65
Progressive - Premium Tier 1 - 3	$105 - 130 copay	Up to $65
Progressive - Premium Tier 4	$85 copay; 20% off retail price less $120 allowance	Up to $65
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$0 copay	Up to $5
Tint - Solid and Gradient	$0 copay	Up to $5
UV Treatment	$0 copay	Up to $5
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $104
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every calendar year	Once every calendar year
Frame	Once every other calendar year	Once every other calendar year
Lenses	Once every calendar year	Once every calendar year
Contact Lenses	Once every calendar year	Once every calendar year

(Plan allows member to receive either contacts and frame, or frames and lens services)

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Parkway School District

2025 Summary of Benefits

PPO Plan 0P

About this Plan:

Anthem Blue Cross and Blue Shield gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

How much is the monthly premium?:
Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

Questions?

Call our **Member Services Team** for answers or plan details and provide them with this group specific code MO004GRS.

Prospective Members, please contact your benefit administrator. When you enroll in the plan you will receive information that tells you where to go online to view your *Evidence of Coverage*.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2025 – 12/31/2025

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$3,400 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Primary care office visit	$0 copay per visit	$0 copay per visit
Specialty care office visit	$0 copay per visit	$0 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$50 copay per visit $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$0 copay per visit	
X-ray visit and/or simple diagnostic test*	$0 copay per visit	$0 copay per visit
Complex diagnostic test and/or radiology visit*	$0 copay per visit	$0 copay per visit
Radiation therapy treatment*	$0 copay per visit	$0 copay per visit
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered basic hearing and balance exams performed by your specialist*	$0 copay per visit	$0 copay per visit
Routine hearing services We have partnered with Hearing Care Solutions to bring you these discounts and services.	Must use a Hearing Care Solutions participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 benefit per ear with a $1,000 maximum benefit every three calendar years	Out-of-network providers must order hearing aids through Hearing Care Solutions. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through Hearing Care Solutions $500 benefit per ear with a $1,000 maximum benefit every three calendar years
Medicare-covered dental is non-routine care performed by your specialist*	$0 copay per visit	$0 copay per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network	**Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Mental health professional individual therapy visit	$0 copay per visit	$0 copay per visit
Substance use disorder professional individual therapy visit	$0 copay per visit	$0 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $50 copay per one-way trip for ambulance services	
Medicare Part B prescription drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services* Medicare-covered	$0 copay per visit	$0 copay per visit
Acupuncture for chronic low back pain* Medicare-covered	$0 copay per visit	$0 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit	$0 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase	$0 copay per purchase
Durable medical equipment (DME) and related supplies*	10% coinsurance per purchase	10% coinsurance per purchase
Opioid treatment program services*	$0 copay per visit	$0 copay per visit
Podiatry services*	$0 copay per visit	$0 copay per visit
Routine foot care	$0 copay per visit 12 visits per year combined in-network and out-of-network	$0 copay per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay for the one time only consultation 1 visit per lifetime	$0 copay for the one time only consultation 1 visit per lifetime

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness programs **SilverSneakers® Membership†** Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel emergency (outside U.S. territories) **Emergency care** Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $50 copay for emergency care $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign Travel - Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $0 copay for urgently needed services
Foreign Travel - Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $0 copay per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-

network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2025 resource: For more information, we encourage you to read Medicare & You 2025. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc.

Parkway School District
Aetna Medicare[SM] Plan (PPO)
Medicare (S02) PPO Plan
Custom Rx $10/$30/$50/25%

Benefits and Premiums are effective January 1, 2025 through December 31, 2025

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No	
Annual Deductible	$0	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	**Network Services:**	**Network and out-of-network services:**
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$4,150	$6,200 for in and out-of-network services combined
It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement , Dental Coverage and Medicare prescription drug coverage that may be available on your plan.		

HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Inpatient Hospital Care	$300 per day, days 1-5; $0 unlimited additional days	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Observation Stay	Your cost share for Observation Care is based upon the services you receive	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay
Outpatient Services & Surgery	$250	25%
Ambulatory Surgery Center	$250	25%
PHYSICIAN SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Primary Care Physician Visits	$10	25%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$25	25%
PREVENTIVE CARE	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare-covered Preventive Services	$0	25%

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy

- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Immunizations • Flu • Hepatitis B • Pneumococcal	$0	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0	25%

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	$50	$50
Urgently Needed Care; Worldwide	$50	$50
DIAGNOSTIC PROCEDURES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Diagnostic Radiology CT scans	20%	25%
Diagnostic Radiology Other than CT scans	20%	25%
Lab Services	$0	25%
Diagnostic testing & procedures	20%	25%
Outpatient X-rays	$15	25%
HEARING SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$25	25%
Medicare Covered Hearing Examination	$25	25%
Hearing Aid Reimbursement	$500 once every 12 months	
DENTAL SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Aetna Enhanced Preventive Dental Value PPO		
Coverage for preventive dental services including cleanings, exams and x-rays		
Annual Benefit Maximum - $750 **Preventive dental services**	$0 dental deductible 0% coinsurance for each covered dental service	$75 out-of-network dental deductible 30% coinsurance for each covered dental service

Medicare Covered Dental*	$25	25%
Non-routine care covered by Medicare.		
VISION SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Routine Eye Exams	$25	25%
One annual exam every 12 months.		
Diabetic Eye Exams	$0	25%
Medicare Covered Eye Exam	$25	25%
Vision Eyewear Reimbursement	$100 once every 24 months	
Applies to in or out of network		
MENTAL HEALTH SERVICES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Inpatient Mental Health Care	$300 per day, days 1-5; $0 unlimited additional days	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$25	25%
Individual visit		
Partial Hospitalization and Intensive Outpatient Services	$25	25%
Inpatient Substance Abuse	$300 per day, days 1-5; $0 unlimited additional days	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse	$25	25%
Individual visit		

SKILLED NURSING SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $40 per day, days 21-50; $0 per day, days 51-100	25% per day, days 1-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	20%	25%

AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	$100	25%

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	Not Covered	

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Part B Prescription Drugs	20%	25%
Medicare Part B Prescription Drugs - Insulin	20% up to $35	20% up to $35

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network providers.	This is what you pay for out-of-network providers.

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Allergy Shots	20%	25%
Allergy Testing	$25	25%
Blood All components of blood are covered beginning with the first pint.	$0	25%
Cardiac Rehabilitation Services	20%	25%
Intensive Cardiac Rehabilitation Services	20%	25%
Chiropractic Services* Medicare covered benefits only.	$20	25%
Diabetic Supplies* Includes supplies to monitor your blood glucose from LifeScan.	$0	25%
Durable Medical Equipment/ Prosthetic Devices*	20%	25%
Home Health Agency Care*	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$25	25%
Outpatient Dialysis Treatments*	20%	20%
Podiatry Services Medicare covered benefits only.	$25	25%
Pulmonary Rehabilitation Services	20%	25%
Supervised Exercise Therapy (SET) for PAD Services	20%	25%
Radiation Therapy*	20%	25%
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Fitness Benefit	SilverSneakers®	

Resources For Living®	Covered	
For help locating resources for every day needs.		
Smoking and Tobacco Use Cessation Supplies	$0	25%
Frequency	unlimited visits every year	unlimited visits every year
Teladoc™	$0	
Telemedicine services with a Teladoc™ provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	$10	25%
Telehealth Specialist	$25	25%
Telehealth Occupational Therapy Services	20%	25%
Telehealth PT and SP Services	20%	25%
Telehealth Other Health care Providers	$25	25%
Telehealth Individual Mental Health	$20	25%
Telehealth Group Mental Health	$20	25%
Telehealth Individual Psychiatric Services	$20	25%
Telehealth Group Psychiatric Services	$20	25%
Telehealth Individual Substance Abuse Services	$25	25%
Telehealth Group Substance Abuse Services	$20	25%
Telehealth Kidney Disease Education Services	$0	25%
Telehealth Diabetes Self-Management Training	$0	25%
Telehealth Opioid Treatment Program Services	$20	25%
Telehealth Urgent care	$50	$50
Wigs*	$0	$0
Maximum	$400	
Frequency	every year	

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Podiatry	$25	25%
Frequency	twenty four visits every year	
Routine Physical Exams	$0	25%
One exam per calendar year		

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

The following plan design is based on our interpretation of preliminary CMS guidance for 2025, but is subject to change when the final guidance is released.

Changes beginning in 2025 include:

- Reduction to three phases - Deductible, Initial Coverage, and Catastrophic
- Elimination of the Coverage Gap Phase
- Introduction of a $2,000 annual out-of-pocket threshold
- Replacement of the Coverage Gap Discount Program with the Manufacturer Discount Program which will provide a 10% manufacturer discount for applicable drugs in the Initial Coverage phase and 20% manufacturer discount for applicable drugs in the Catastrophic phase.

Calendar-Year Deductible for Prescription Drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$10	$20	$20

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	Preferred Mail	Standard Retail or Mail
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$30	$60	$60
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$50	$100	$100
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	25%	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,000 for covered Part D prescription drugs is reached.

Medical Premiums for Medicare Advantage Plans (age 65)

UHC Base Plan AND Anthem Advantage Medical Monthly Premiums			
	Retiree Only on Anthem Medicare & Spouse/Child on UHC Base Plan	Retiree & Spouse on Anthem Medicare & Dependents on UHC Base Plan	Retiree & Dependents on UHC Base Plan & Spouse Only on Anthem Medicare
Retiree Only	$357.47	$357.47	$759.99
Retiree & Spouse	$1,117.46	$714.94	$1,117.46
Retiree & Spouse + 1 Child	$1,393.90	$991.38	$1,393.90
Retiree & Spouse + Children	$1,681.92	$1,279.40	$1,681.92
Retiree + 1 Child	$633.91	$633.91	$1,036.43
Retiree + Children	$921.93	$921.93	$1,324.45

UHC Base Plan AND Aetna Advantage Medical Monthly Premiums			
	Retiree Only on Aetna Advantage & Spouse/Child on UHC Base Plan	Retiree & Spouse on Aetna Advantage & Dependents on UHC Base Plan	Retiree & Dependents on UHC Base Plan & Spouse Only on Aetna Advantage
Retiree Only	$352.43	$352.43	$759.99
Retiree & Spouse	$1,112.42	$704.86	$1,112.42
Retiree & Spouse + 1 Child	$1,388.86	$981.30	$1,388.86
Retiree & Spouse + Children	$1,676.88	$1,269.32	$1,676.88
Retiree + 1 Child	$628.87	$628.87	$1,036.43
Retiree + Children	$916.89	$916.89	$1,324.45

UHC Premium Plan AND Anthem Advantage Medical Monthly Premiums			
	Retiree Only on Anthem Medicare & Spouse/Child on UHC Premium Plan	Retiree & Spouse on Anthem Medicare & Dependents on UHC Premium Plan	Retiree & Dependents on UHC Premium Plan & Spouse Only on Anthem Medicare
Retiree Only	$357.47	$357.47	$906.42
Retiree & Spouse	$1,263.89	$714.94	$1,263.89
Retiree & Spouse + 1 Child	$1,673.19	$1,124.24	$1,673.19
Retiree & Spouse + Children	$2,047.57	$1,498.62	$2,047.57
Retiree + 1 Child	$766.77	$766.77	$1,315.72
Retiree + Children	$1,141.15	$1,141.15	$1,690.10

UHC Premium Plan AND Aetna Advantage Medical Monthly Premiums			
	Retiree Only on Aetna Advantage & Spouse/Child on UHC Premium Plan	Retiree & Spouse on Aetna Advantage & Dependents on UHC Premium Plan	Retiree & Dependents on UHC Premium Plan & Spouse Only on Aetna Advantage
Retiree Only	$352.43	$352.43	$906.42
Retiree & Spouse	$1,258.85	$704.86	$1,258.85
Retiree & Spouse + 1 Child	$1,668.15	$1,114.16	$1,668.15
Retiree & Spouse + Children	$2,042.53	$1,488.54	$2,042.53
Retiree + 1 Child	$761.73	$761.73	$1,315.72
Retiree + Children	$1,136.11	$1,136.11	$1,690.10

Medical Premiums for Medicare Advantage Plans - Continued

UHC High Deductible Plan AND Anthem Medicare Monthly Premiums			
	Retiree Only on Anthem Medicare & Spouse/Child on UHC High Deductible Plan	Retiree & Spouse on Anthem Medicare & Dependents on UHC High Deductible Plan	Retiree & Dependents on UHC High Deductible Plan & Spouse Only on Anthem Medicare
Retiree Only	$357.47	$357.47	$629.22
Retiree & Spouse	$986.69	$714.94	$986.69
Retiree & Spouse + 1 Child	$1,201.69	$929.94	$1,201.69
Retiree & Spouse + Children	$1,433.05	$1,161.30	$1,433.05
Retiree + 1 Child	$572.47	$572.47	$844.22
Retiree + Children	$803.83	$803.83	$1,075.58

UHC High Deductible Plan AND Aetna Advantage Medicare Monthly Premiums			
	Retiree Only on Aetna Advantage & Spouse/Child on UHC High Deductible Plan	Retiree & Spouse on Aetna Advantage & Dependents on UHC High Deductible Plan	Retiree & Dependents on UHC High Deductible Plan & Spouse Only on Aetna Advantage
Retiree Only	$352.43	$352.43	$629.22
Retiree & Spouse	$981.65	$704.86	$981.65
Retiree & Spouse + 1 Child	$1,196.65	$919.86	$1,196.65
Retiree & Spouse + Children	$1,428.01	$1,151.22	$1,428.01
Retiree + 1 Child	$567.43	$567.43	$844.22
Retiree + Children	$798.79	$798.79	$1,075.58

United Health Care Programs

Register for your personalized website on myuhc.com and download the United Healthcare app.

Get the most out of your benefits! These digital tools are designed to help you understand your benefits and make informed decisions about your care.

Find care and compare costs for providers and services in your network. Check your plan balances, view your claims and access your health plan ID card. Access wellness programs and view clinical recommendations. View your health care financial account(s) such as HSA.

Real Appeal

Real Appeal is a weight loss and health lifestyle program, available to eligible Parkway School District Retirees 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 Retirees, 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
www.parkway.realappeal.com

24/7 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. 24/7 Virtual Visits provide fast, convenient, on-demand access to care without having to leave home or the workplace. Members have the ability to see and speak with a doctor anywhere, anytime on a mobile device or computer. Members access an integrated experience through myuhc.com and the United Healthcare app.

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 until it’s resolved.” This service is offered at no charge to United Healthcare members.

Wellness Offerings – UHC members only

Wellness Offerings

The goal of employee/retiree wellness at Parkway is simple. We wish to create and maintain a culture of health. We wish to provide a positive, inclusive, holistic wellness programs that employees and retirees 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/retirees.

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 2025 Include (but not limited to):

- Care ATC Employee Clinics providing accessible and great primary care, Immunizations, Personal health assessments
- Personal Assistance Services (PAS), 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
- Onsite mobile mammography van
- Maven Maternity
- KAIA and 2nd MD
- Virtual Therapy
- **One Pass Select** – a holistic offering that includes physical & digital fitness options

THESE OFFERINGS ARE ONLY OPEN TO MEMBERS WHO ARE ON ANY OF THE UHC MEDICAL PLANS. ACCESS VIA myuhc.com.

In addition to the listed wellbeing opportunities, the employer sponsors various wellbeing offerings and challenges each year, related to mental wellbeing, movement, eating well and preventive care. Contact Leah Gonzalez, Wellness Coordinator at lgonzalez1@parkwayschools.net or (314) 415-8034.

One Pass Select™

Rediscover your passion for health

With One Pass Select, we're on a mission to make fitness engaging for everyone. One Pass Select can help you reach your fitness goals, while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan. You and your eligible family members (18+) can get started with One Pass Select on January 01, 2024.

Find your fit with One Pass Select

At the gym

Choose from our large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

At home

Work out at home with live or on-demand online fitness classes. Try our workout builder to get routines created just for you, no matter what your fitness level and interests are.

In the kitchen

Get groceries and household essentials delivered to your home. We make it easy to plan for everything you need to enjoy delicious, nutritious meals.

$29/Mo

Classic

11,000+ gym locations

$64/Mo

Standard

12,000+ gym and premium locations

$99/Mo

Premium

14,000+ gym and premium locations

$144/Mo

Elite

16,000+ gym and premium locations

Learn more about One Pass Select* at OnePassSelect.com.

Enroll in One Pass Select starting on January 01, 2024

***Eligible One Pass Select members will not be able to enroll in One Pass Select until January 01, 2024.**

An enrollment fee may apply

Or get started with a digital-only plan for $10/Mo

All tiers Classic or above come with grocery and home essentials delivery at no extra cost.

United Healthcare

Teladoc HEALTH

Live healthier at no cost to you

$0
cost to you

When you join, you'll have access to connected chronic care management devices and the support you need. It's all available to you and 100% paid for by your plan sponsor.

Diabetes Management
- ✓ Connected meter
- ✓ Unlimited strips

Hypertension Management
- ✓ Connected monitor
- ✓ One-on-one coaching

Weight Management and Diabetes Prevention Program
- ✓ Connected scale
- ✓ Expert guidance

...And more programs!
- ✓ Health experts
- ✓ Personalized plans

Get started

Visit **TeladocHealth.com/Smile**
Or call **800-835-2362**

Program includes trends and support on your secure Teladoc Health account and mobile app but does not include a phone, tablet or smartwatch.

Las comunicaciones del programa Teladoc Health están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al 800-835-2362 o visite TeladocHealth.com/Hola

Program eligibility varies. Visit our website to learn more.

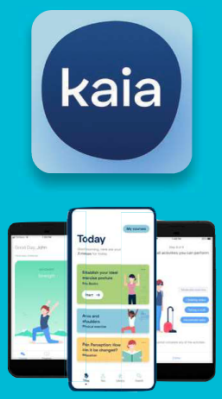
Don’t wish pain away … do this instead

Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier

Whether it’s a stiff neck, aching shoulders or more severe back issues, it can be hard to enjoy life when pain shows up. That’s where Kaia steps in. It’s a new app here to show how pain relief is possible — **at no extra cost** as part of your health plan.

Connecting with Kaia connects you with so much

- **On-demand pain relief care** in the convenience of an app
- **1-on-1 health coaching** with certified professionals
- **Workouts tailored to you** with some as short as 15 minutes
- **No extra cost—**this is included as part of your health plan
- **Bite-sized lessons** to help you recognize where pain is coming from
- **Strengthening exercises** plus relaxation techniques for pain management



Download Kaia today

You’ll get a personalized pain relief program created on the spot after you sign up. Get started with a personalized pain relief program and learn helpful exercises with no scheduling, waiting rooms or travel required.

Download on the App Store | GET IT ON Google Play

For real-time feedback while you exercise

Kaia tracks your movements using AI technology to ensure you’re doing each exercise correctly, providing real-time audio and video feedback for help along the way. So you get a program tailored to your fitness, pain and mobility levels to help manage pain.

Visit startkaia.com/uhc

United Healthcare | kaia health

*Provided at no extra cost as part of your health plan.

Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.

Reaching out may be hard—especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device* or computer, you can receive caring support from a licensed behavioral health virtual therapist.

Virtual therapy offers confidential counseling and includes:

Private video sessions.

Get 1-on-1 support—in your home and at a time that's convenient for you.

Help with coping—for children, teens and adults.

Your licensed virtual therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits.

You can see the same therapist with each appointment and establish an ongoing relationship.

A quicker way for the whole family to get care.

Virtual therapy may be a great way for children and teens to get an appointment.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Mental health disorders

To find a provider and schedule a visit:

1. Sign in or register on **myuhc.com®**. Then, go to **Find a Doctor > Mental Health Directory > People > Provider Type > Telemental Health Providers**.
2. Call the provider to set up an appointment.

United Healthcare®

2nd.MD
Specializing in Medical Certainty

WE SPECIALIZE IN **MEDICAL CERTAINTY**

Through your company, you have an exclusive membership to 2nd.MD, a virtual expert medical consultation and navigation service. We connect you with a board-certified, elite specialist for a virtual expert medical consultation via phone or video from the comfort of home.

2nd.MD specializes in medical certainty by providing access to elite specialists for questions about:

- Diseases, cancer, or chronic conditions
- Surgeries or procedures
- Medications and treatment plans

WHO IS ELIGIBLE?

2nd.MD is confidential, fast and no additional cost to you and covered dependents on the UnitedHealthcare medical plan.

GET STARTED TODAY

Call at 1.866.269.3534
Visit www.2nd.MD/activate
or download our 2nd.MD app

Download on the App Store | GET IT ON Google Play

CALL 911 IMMEDIATELY IF YOU ARE HAVING A MEDICAL EMERGENCY. 2nd.MD is not an emergency service. 2nd.MD is an independent resource to support you in receiving information from Expert Medical Specialists. 2nd.MD does not practice medicine or provide patient care and is independent from the Specialists providing the expert medical consultations.

HOW IT WORKS:
3 Simple Steps

1. **ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT**
   Visit www.2nd.MD/activate, download our app or call us at 1.866.269.3534

2. **SPEAK WITH A NURSE**
   Explain your medical issues and an experienced nurse will handle the rest, including collecting medical records and connecting you with a leading specialist who is an expert in your condition.

3. **CONSULT WITH A LEADING SPECIALIST** Get information about your diagnosis, treatment plan and next steps in care from a nationally recognized specialist. Consult via video or phone at a time that works best for you, including evenings and weekends!

AFTER YOUR CONSULTATION

You'll receive a written summary of your consultation so you're prepared for a conversation with your treating doctor or we can refer you to another in-network doctor in your area.

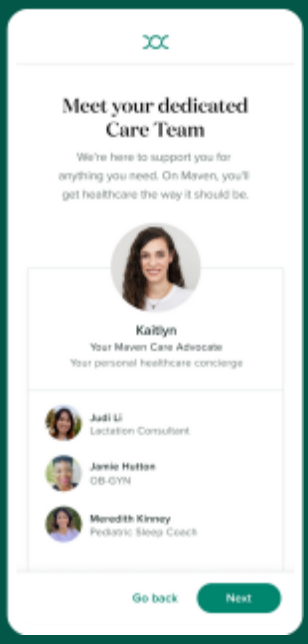
See how one member avoided an unnecessary surgery and learned how to manage her rare condition.

MAVEN

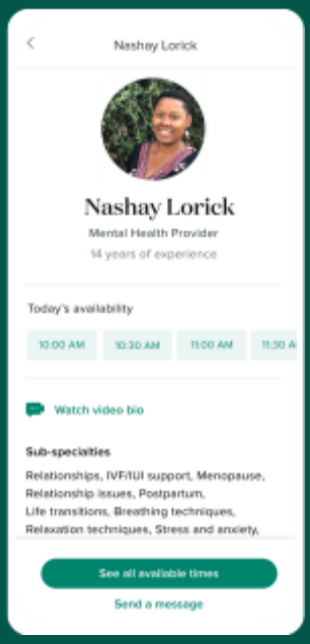
Meet Maven. Free virtual support for those sleepless nights, first smiles, and everything in between.

You and your partner have free access to Maven for 24/7 pregnancy and postpartum support and guidance–all in one app.

Your membership includes:



24/7 personalized support
from a dedicated Care Advocate



Virtual appointments and messaging
with providers–any time day or night

On-demand classes, groups and articles
for expert guidance you can trust

Get support with things like:

- Creating your birth plan
- Breastfeeding or bottle feeding support
- Navigating infant sleep
- Returning to work
- Managing your mental health

Scan the QR code to get started or go to mavenclinic.com/join/uhc-join or download the Maven Clinic app

Join today for free

The CareATC Difference

Meet Your St. Louis Area Providers

David **Dunn, MD**
Claymont Health Center

Rachel **Mergenmeier, DO**
McKelvey Park Health Center

Nicholas **Powers, DO**
Keaton Health Center

Rosemary **Wensley, MD**
Dougherty Ferry Health Center

Michael **Barajas, PA**
Dougherty Ferry and Keaton

Erin **Keller, LCSW**
Dougherty Ferry Health Center

Jackie **Bode, NP**
McKelvey Park

Treatments and services include:

- Allergies / Asthma
- Cold / Flu / Congestion
- Diabetes Management
- Headaches
- High Blood Pressure
- High Cholesterol
- Lab Work/Tests
- Mental Health
- Occupational Health *(referral required)*
- Personal Health Assessments (PHA)
- Physicals
- Sports Physicals
- Thyroid Disorders
- Tobacco Cessation
- Weight Management
- Well Woman Exams

CareATC
THE POWER TO BE WELL.

CareATC Health & Wellness Center

Area Health Center Locations

Pay nothing, get a lot.

- No co-pay
  (Office visit fee may apply for HSA participants.)
- Quick and easy appointments
- Preventive care, as well as illness, injury, and chronic disease management
- Free lab work and generic medications provided during your visit
- Less wait time, more face time with your medical provider
- No insurance billing

Claymont Health Center
15421 Clayton Rd,
Ballwin
M/W/F 7am - 4pm
Tu/Th 8am - 5pm

Dougherty Ferry Health Center
2315 Dougherty Ferry Rd
Ste 110, St. Louis
M - F 8am - 12pm / 1 - 5pm

Keaton Health Center
6698 Keaton Corp Pkwy
Ste 101, O'Fallon
M/W/Th/F 7am - 4pm
Tu 9am - 6pm

McKelvey Park Health Center
3165 McKelvey Rd
Ste 205, Bridgeton
M - F 7:30am - 4:30pm

Three Easy Ways To Schedule:

Call **314.314.7434**

Visit **www.careatc.com/patients**

Download the **CareATC app**

CareATC
THE POWER TO BE WELL.

Show Me The App!

Who is Eligible for CareATC Clinics?

All UHC Covered Employees & Retirees

All UHC Covered Dependents

CareATC Mobile App

24/7 Appointment Scheduling

Schedule in-person and virtual visits.

Prescription Refill Requests

Never run out of essential medications.

Message Your Care Team

Connect with your care team with secure messaging.

CareATC
THE POWER TO BE WELL.

Show Me The App!

Employee Assistance Program

Available to Retirees and their Families Who Are On Any UHC Medical Plan

Parkway School District also provides you access to the Employee Assistance Program (EAP) at no cost. This program, available through PAS, provides professional, confidential telephonic or face-to-face counseling services to you and your loved ones. The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance.

This program is available 24 hours a day, 365 days a year for confidential assistance and referral services with items such as:

- Managing stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Child care issues — including identifying schools, daycare, tutors, and more
- Aging parents

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

To book an appointment or get other information about PAS:

- Go to MyPASEAP.com.
- Use Organization Code: PARKWAY SD (Parkway's website code is Parkway SD. Must be capitalized)

or

- Call 800-356-0845 or download the PAS app
- Use Employer Code: PARKWAY SD

Parkway School District's PAS Mindfulness Benefit: eM Life

Discover a proven way to take on life's challenges

eM Life is a live, virtual mindfulness solution to help you create connections with yourself and others while building skills to manage stress and anxiety, improve focus and enhance your overall well-being.

eM Life is available to you, your spouse, and your dependents as part of your benefits package.

Step 1. Download eM Life from the App Store or Google Play.

App Store | Google Play

Step 2. Scan this QR code to create an account.

Optional: Or **click below** to sign up online.

Desktop App Sign Up

https://vibe.emindful.com/signup/ParkwaySD

One Solution, Many Features:

- Live daily 14-minute mindfulness programs led by experts multiple times a day
- Live monthly online programs led by experts covering everything from stress to weight balance
- Hundreds of hours of on-demand content on a wide range of topics including leadership, diversity and inclusion and anxiety
- Expert-led community to gain support and purpose

eM Life helps you:

- Reduce Stress and Anxiety
- Boost Immunity
- Improve Sleep
- Enhance Focus
- Build Connections with Yourself and Others

Multi-Week Immersive Programs

- Better Living with Diabetes™
- Cultivating Compassion
- Living Well with Chronic Pain™
- Mindfully Overcoming Addictive Behaviors
- Mindfulness At Work™
- Mindfulness-Based Cancer Recovery™
- Mindfulness-Based Cognitive Training
- QuitSmart® Mindfully
- Skills to Thrive in Anxious Times
- The Journey Forward: Your M.M.A.P. For Success
- Weight Balance for Life™

Guidelines for Retiree Benefits

RETIREE INSURANCE COVERAGE

Retirees can continue their participation in Parkway's group medical, dental and vision plans. We do not offer group life insurance or other voluntary insurances to retirees. However, employees who retire or leave the district shall have the opportunity to convert their life insurance to individual policies, subject to the limitations established by the insuring company.

Enrollment

The Benefits Department will send information via email on how to continue group health coverage after an employee notifies HR of their planned retirement date. Additionally, Retirees may visit the Benefits website for the most up to date information on their benefits options and coverage.

Retirees who choose not to continue their medical, dental and/or vision coverage at the time of retirement will be granted one (1) year from the date their district-paid benefits end to return to Parkway's group coverage. In addition, Retirees may add a spouse or dependent child(ren) (under age 26) to their coverage during the one (1) year period. No exceptions will be made to this timeframe.

Canceling Coverage (not a qualifying life event)

Retirees may cancel their group health insurance coverage at any time. However, coverage will be in effect until the end of the month in which we receive a cancellation request.

To cancel coverage, a cancellation form (posted on our website) must be completed and submitted to the Benefits Department no later than 5 business days prior to the first day of the month that you wish to drop coverage. Example: to drop coverage for May, you would have to notify us no later than 5 business days prior to May 1. We can accept the form via email, mail, or you can drop it off.

Payment of Premiums

Retirees who choose to continue their group health coverage are responsible for paying the full cost of their premiums. Premiums are collected using ACH direct debit. Premiums are collected from one (1) account which can be set up by the retiree. The account on file can be changed at any time, provided we are notified 3 business days prior to the next scheduled payment. Retirees can choose for their monthly payment to occur on either the 1st or the 15th of each month. Payment is for the current month of coverage. Coverage will be permanently terminated for any account that is more than 60 days past due. Additionally, any account with several consecutive late payments will be considered for termination.

When a scheduled ACH payment request is returned, the Benefits Department will attempt to notify the retiree by phone, email, and/or mail. Upon notice, we request that payment arrangements be made for the returned payment. A $10 return fee will be added to the account balance.

Guidelines for Retiree Benefits

HSA funds will not generally be accepted as payment for retiree insurance premiums. Per IRS Publication 969:Health Savings Accounts and Other Tax-Favored Health Plans, you can't treat insurance premiums as qualified medical expenses unless the premiums are for any of the following:

1. Long-term care insurance. CAUTION

2. Health care continuation coverage (such as coverage under COBRA).

3. Health care coverage while receiving unemployment compensation under federal or state law.

4. Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

For further guidance, please review IRS Publication 969 or consult with a certified tax preparer. Parkway is not responsible for any issues caused from using or contributing HSA funds after retirement.

Medicare Eligibility

The retiree must notify the Benefits Department when they are medicare-eligible if they wish to cancel their group health coverage.

The district offers two (2) medicare advantage plans for medicare-eligible retirees and their spouses. We will notify retirees of their options through our annual open enrollment communications.

These plans are not managed by Parkway. They are provided as a courtesy to our retirees and provide additional and optional coverage for our retirees that are medicare enrolled. For more information or to sign up for either these plans, please contact the Benefits Department.

COBRA after Retirement

The Benefits Department will offer COBRA Continuation Coverage to the qualified beneficiaries of retirees in the event that they experience a qualifying event.

Important Contacts

Plan	Whom To Call	Phone	Website
Employee Clinic	CareATC	1-314-314-7434	www.careatc.com
Pharmacy	Express Scripts	1-877-777-8225	www.express-scripts.com
Health Advocate	United Healthcare	Call Number on Back of Medical ID Card	www.myuhc.com
Wellness Program	Wellness Coordinator	314-415-8034	
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
Health Savings Account (HSA)	Optum Bank	1-800-791-9361 (Option 1)	www.optumbank.com
Anthem Help Line	Anthem Customer Svc CarelonRx New Member Help Line	1-833-848-8730 1-833-360-3662 1-833-848-8729	www.anthem.com
Aetna Medicare Advantage	Aetna Customer Svc & CVS Caremark Rx New Member Help Line	1-855-275-5888 1-800-307-4830	www.aetnaretireeplans.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.sunlife.com
Vision	EyeMed	1-866-800-5457	www.eyemed.com/member
Employee Assistance Program (EAP)	PAS	1-800-356-0845	www.paseap.com
Benefits Team		**Phone**	**Website**
General Benefits Email			benefits@parkwayschools.net
Coby Peters	Benefit Specialist	1-314-415-8059	cpeters@parkwayschools.net
Deb Nolan	Benefits Coordinator	1-314-415-8049	dnolan@parkwayschools.net
Leah Gonzalez	Coordinator, Employee Wellbeing	1-314-415-8034	lgonzalez1@parkwayschools.net
Dawne Trokey	Executive Director of Finance	1-314-415-8060	dtrokey1@parkwayschools.net

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form, and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don't contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

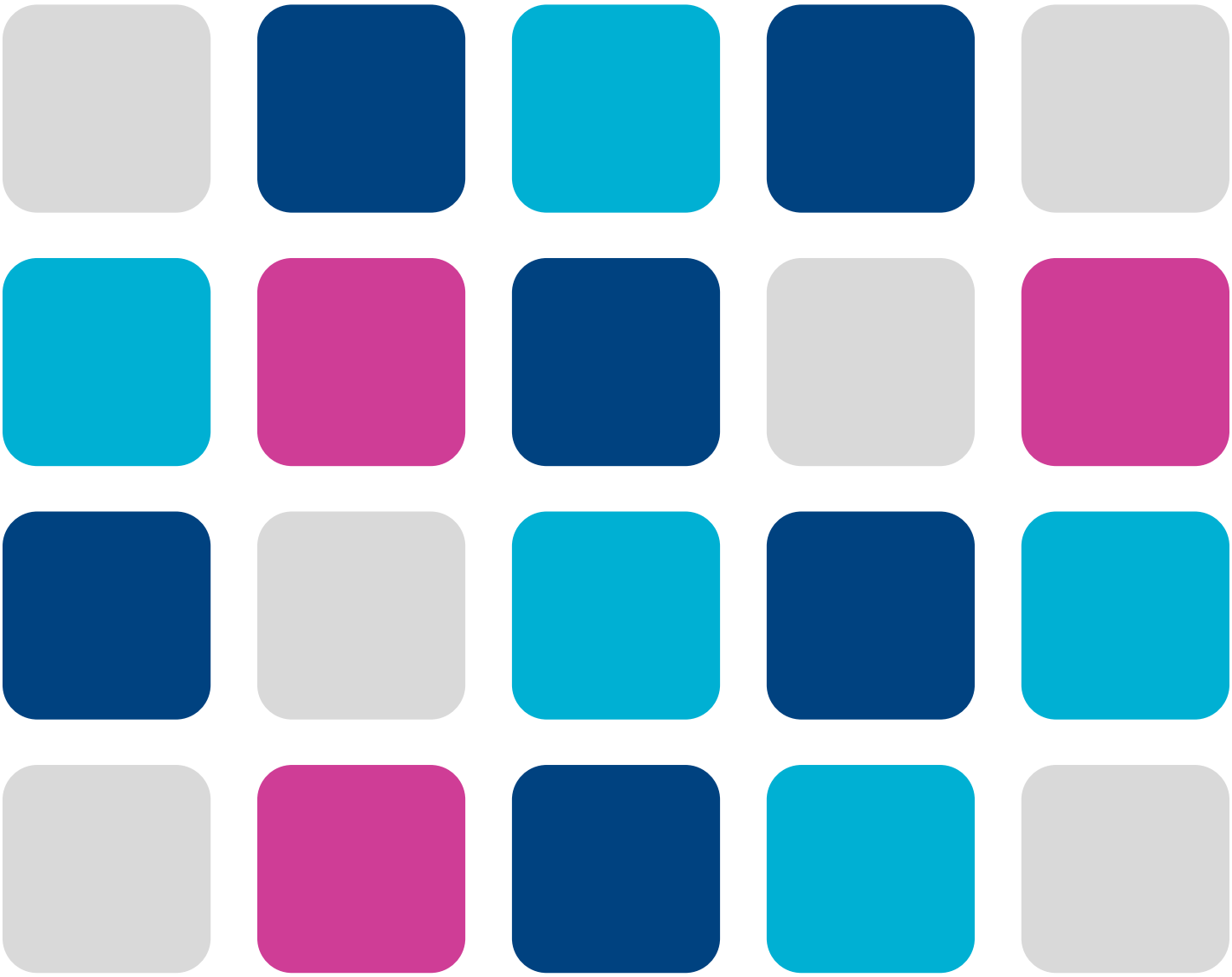
Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

NOTES:



MARSH & McLENNAN AGENCY