2022

CITY OF ST. CHARLES SCHOOL DISTRICT

EMPLOYEE BENEFITS GUIDE

Welcome to the 2022 Benefits Open Enrollment

The City of St. Charles School District's annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

Open enrollment runs

November 1st – November 15th

Enroll online at

www.mycscsdbenefits.com

NOT SURE HOW TO GET STARTED?

DON'T WORRY!

Annual enrollment is handled online through CBAS. This system allows you to review and/or change your benefit information 24 hours a day, seven days a week.

- **Login**: First Initial of First Name + First Initial of Last Name + Last 4 of SSN / **Password:** Date of Birth (MMDDYYYY)
- Review the benefits in which you are currently enrolled. Check out the plans being offered for the upcoming year
- This year's enrollment is an ***ACTIVE*** enrollment. This means all employees must either log on to the CBAS system and enter their 2022 enrollment. Your current enrollments will ***NOT*** rollover to the new plan year.

In this booklet, you'll find easy-to-understand information to help you make your benefit decisions.

As always, we value you as a member of the City of St. Charles School District family and look forward to a healthy and safe 2022.

REMEMBER:

Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact the carriers listed below or your City of St. Charles School District's Benefits Specialist, or our CBIZ representatives listed below.

Medical Insurance: Group Number 76413023
UMR
umr.com
800.826.9781

Prescription Drug Plan: Group Number SL 902127
Optum
optumrx.com
855.896.9779

Dental Insurance: Group Number 5954780
MetLife
metlife.com/mybenefits
800.942.0854

Vision Insurance: Group Number 1012726
EyeMed
866.804.0982
eyemed.com/member

Basic Life and AD&D, Dependent Life, Voluntary Life & AD&D and Voluntary Short Term Disability Insurance: Group Number 157948 (Life)/303281 (STD)
Reliance
855.775.2524
rslclaims.com

Flexible Spending Account
Wex Health
wexinc.com
866.451.3399

Employee Assistance Program
Reliance (ACI)
rsli.acieap.com
855-775-4357

Worksite: Group Number 8843256
UNUM
800.635.5597
www.unum.com/claims

Your City of St. Charles School District Benefits Team
Tammy Herter
therter@stcharlessd.org
636.443.4047

CBIZ Representative(s)
Asha Kuhn
akuhn@cbiz.com
314.692.5834
Eric File
efile@cbiz.com
314.692.5848

TABLE OF CONTENTS

Throughout this booklet you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

HOW TO GET STARTED

1 SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1:** Premium Plan
- ☐ **OPTION 2:** Base Plan
- ☐ **OPTION 3:** QHDHP

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis or 25 hours per week for Bus Drivers.

Will I receive a new Medical ID card?

You will receive a new ID card in the mail if you are electing medical coverage. Or renewing your current coverage.

Does the deductible run on a calendar year or policy year basis?

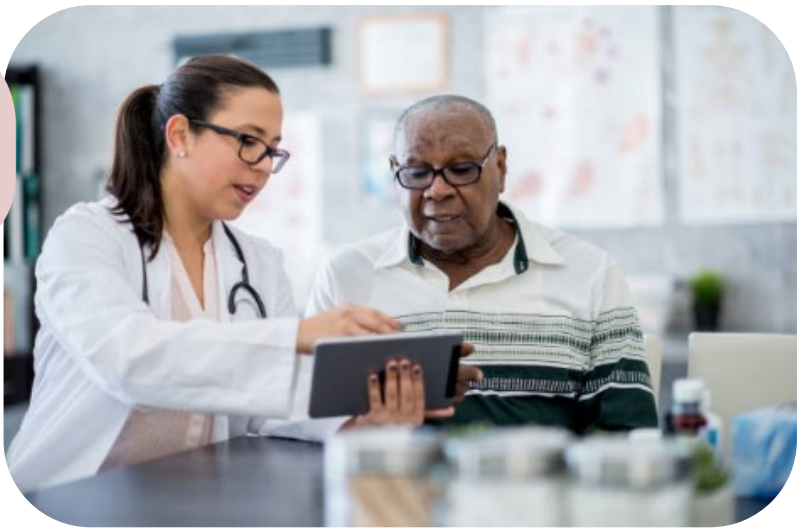
A calendar year basis.

How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on your date of hire.



YOUR HEALTH PLAN OPTIONS

As a full-time employee of the City of St. Charles School District, you have the choice between six medical plan options: a Premium Plan, Base Plan and Qualified High Deductible Health Plan (QHDHP). Each plan has the option of enrolling in the full UMR network or the Core UMR Network. **The Core network does *not* include BJC providers or hospitals. If you are enrolled in the Core plan and chose to seek services with a BJC provider, your services will apply toward the out of network deducible and out of packet maximum limits.**

For each, your deductible will run from January 1–December 31.

While all plans give you the option of using out-of-network providers, you can save money by using in-network providers because UMR has negotiated significant discounts with them. For services received from a non-network provider, claims for covered expenses will normally be processed in accordance with the out-of-network benefit level and your out-of-pocket will be higher than when a network provider is utilized.

The Base plan offers you significantly lower premiums than the Premium Plan. The Base Plan and QHDHP offer you a no cost option for employee only coverage. If you enroll in the QHDHP can establish a Health Savings Account (HSA) with UMB Bank. The funds that are contributed into this account can be used to cover medical expenses, including deductibles, and they're yours forever—even if you leave the City of St. Charles School District. **As well, the City of St. Charles School District will contribute $1,200 into the HSA for the 2022 plan year**. $600 will be deposited In January and the remaining $600 will be deposited in March. Unlike a Flexible Spending Account (FSA), funds are not forfeited at the end of each year.

THE QHDHP OFFERS SEVERAL BENEFITS:

- Lower potential maximum out-of-pocket expenses when you take into account the District's contribution
- Routine preventive exams are covered at 100%
- Catastrophic coverage
- The HSA is owned by you
- You have more control over your health care dollars

THE PREMIUM AND BASE PPO PLANS MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You are not interested in establishing a Health Savings Account
- You would rather pay more in monthly premiums and less on medical expenses when they occur
- You expect to incur medical expenses at the beginning of the year and don't have the resources to pay for them

▶ Medical Plans Explained

Care Options

Primary Care vs. Urgent Care vs. ER

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

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Chronic Disease Management

THE BRIDGE

- Preventive Care
- Minor injuries
- Acute Illness
- Vaccines
- Medications
- Lab work

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

PRIMARY CARE

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

THE BRIDGE

The Bridge Health Center is available to you and your family members enrolled in the medical plan. The Bridge offers you a convenient location for medical services such as preventive care, disease management, acute illness care, minor injuries, medication, lab work and vaccinations. The Bridge offers you a ***no cost*** option for eligible services if you are enrolled in the Base or Premium plan. Services are available at a reduced cost if you are enrolled in the QHDHP.

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening.

Emergency services are always considered in -network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

MEDICAL INSURANCE PLAN OPTIONS & COSTS

UMR	Option 1: Premium Plan	Option 2: Base Plan	Option 3: QHDHP *(see HSA note below)*
	Employee Cost [Per Month] With BJC/Without BJC	**Employee Cost [Per Month] With BJC/Without BJC**	**Employee Cost [Per Month] With BJC/Without BJC**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$52 / $15 $730 / $665 $595 / $545 $1,342 / $1,240	$0 / $0 $450 / $374 $330 / $285 $790 / $695	$0 / $0 $405 / $337 $300 / $248 $715 / $624
	In-Network	**In-Network**	**In-Network**
Deductible (1) Individual / Family	$500 / $1,000	$750 / $1,500	$3,000 / $6,000
Coinsurance (Member Pays)	0%	10%	0%
Out-of-Pocket Maximum (2) Individual / Family	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Office Visits Preventative Care Primary Care Physician / Specialist **The Bridge Office Visit** Diagnostic Lab / X-Ray **The Bridge Lab Work** Urgent Care **The Bridge Acute Care**	Covered at 100% $35 / $40 copay **$0 copay** Deductible **$0** $125 copay **$0**	Covered at 100% $40 / $50 copay **$0 copay** Deductible then 10% **$0** $150 copay **$0**	Covered at 100% Deductible **Fair Market Cost** Deductible **Fair Market Cost** Deductible **Fair Market Cost**
Hospital Visits Inpatient Care (Facility/ Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	Deductible Deductible Deductible $250 copay	Deductible then 10% Deductible then 10% Deductible then 10% $300 copay	Deductible Deductible Deductible Deductible
Prescription Drug (Optum) Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	$3,000 out of pocket max. N/A $10 / $25 / $50 2 times copay	$3,000 out of pocket max. $150 $10 / $30 / $70 2 times copay	Deductible Then: $0 $0 $0
	Out-of-Network (3)	**Out-of-Network (3)**	**Out-of-Network (3)**
Deductible Individual / Family	$1,000 / $2,000	$1,500 / $3,000	$6,000 / $12,000
Coinsurance (Member Pays)	30%	40%	30%
Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$6,000 / $12,000	$12,000 / $24,000

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays with the exception of prescription copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

HSA Note: For the 2022 benefit year HSA participants who qualify and establish a Health Savings Account with UMB Bank will receive an employer contribution of $1,200 into the HSA. $600 will be deposited in January and the remaining $600 will be deposited in March.

IMPORTANT: To see how UMR is handling testing, inpatient hospital admissions (including treatment), telehealth visits, etc. as a result of COVID-19 visit their website here: umr.com. All plans are detailed in UMR's Summary Plan Description (SPD). This is a brief summary only. For exact terms and conditions, please refer to your SPD.

UMR
ADDITIONAL PROGRAMS

UMR PLAN ADVISOR

Navigating health care can be tricky, which is why no question is a bad one. Your plan advisor is ready to go over your benefit details with you, or connect you to the right person to find the answer you need, so you won't be caught by surprise.

Plan Advisor can help you:

- Look into a recent medical claim to make sure it was paid correctly
- Check to see what your our of pocket cost are for services
- See how much you have paid and how much you have left of your individual or family deductible
- Discover what service are available to you based on your plan

Plan Advisors are available weekdays from 7am to 5 pm CST at 1.00.826.9781

UMR CARE

UMR CARE has a staff of experienced, caring nurses (RNs) who help you get the most out of your health plan benefits. They work with you, your doctors and other medical advisors to get the services that best meet your needs. The expert CARE nurses can guide you before, during and after your medical care.

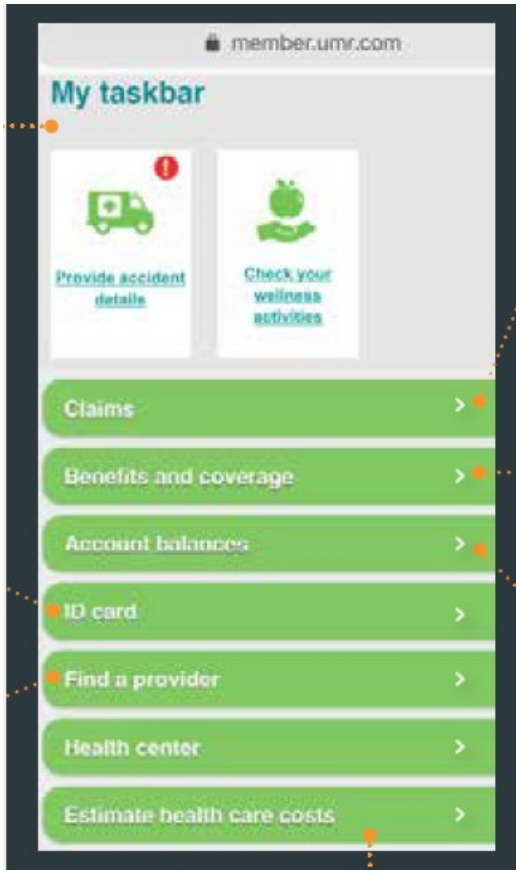
If you have questions about your CARE benefits or upcoming health care services, call UMR CARE at the phone number provided on your medical ID card.

UMR.COM

umr.com is your personalized member website to help you access and manage your medical plan information 24/7. The website allows you to check your benefits and see what's covered, look up what you owe and how much you've paid, find a doctor in your network, access tools and trusted resources to help you live a healthier life, access your health plan ID card as well as learn about medical conditions and treatment options

UMR ON-THE-GO

As a UMR member you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download. Simply log in to umr.com.



HEALTH SAVINGS ACCOUNT (HSA)

2 REVIEW YOUR HSA

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

Two ways you can put money into your HSA:

1. Regular payroll deductions on a pre-tax basis;
2. Lump-sum contributions of any amount, anytime, up to the maximum limit.

You are not required to establish an HSA if you enroll in the QHDHP, however if you do not, you will not be eligible for the Districts' HSA contribution of $1,200 for the 2022 plan year.

WHAT IS AN HSA?

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

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds—or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, any unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future—even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses—even if they're not covered by your medical plan.

CONTRIBUTE UP TO $3,650 AS A SINGLE PERSON & $7,300 AS A FAMILY (THIS IS A COMBINATION OR EMPLOYEE AND EMPLOYER CONTRIBUTIONS TO THE HSA)

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or Tricare due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit each calendar year. After the District's HSA contribution is applied on your behalf, an employee can contribute up to $2,450 for employee only coverage and $6,100 for family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications
- Physical therapy, speech therapy, and chiropractic expenses

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

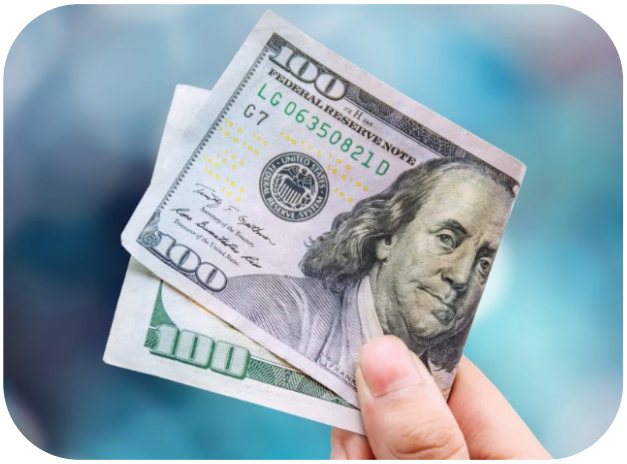
Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

This may be the best plan option for you if any of the following is true:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.



FREQUENTLY ASKED QUESTIONS

What will I pay at the pharmacy with the HSA qualified plan options?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

What will I pay at the physician's office with the HSA qualified plan?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to UMR. You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from UMR that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

Where can I get a copy of an EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to umr.com.

FLEXIBLE SPENDING ACCOUNT (FSA)

3 SELECT YOUR FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware—any unused portion of the account at the end of the plan year is forfeited.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible Amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

[What is a Flexible Spending Account?]

[Full list of Eligible Examples]

2022 Maximum Contributions

Health Care Flexible Spending Account	$2,850 max
Dependent Care Expense Account	$5,000 max

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to CBIZ. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

Carry Over Provision - *(Medical Only)*

If you allocate money to a certain benefit during the plan year (1/1-12/31), you must use all the money for that benefit during the plan year (example; expenses have to be incurred but not necessarily paid for), with the exception of $570 under the Health Reimbursement Account.

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Contact Information

Request a full statement of your accounts at any time by calling 866.451.3399 or log on to www.wexinc.com to review your FSA balance and file claims.

DENTAL INSURANCE

4 REVIEW YOUR DENTAL PLAN

FIND A DENTIST

To find a MetLIfe provider in your area, visit the website at metlife.com/mybenefits

- Click on Find a Dentist
- Select the "PDP Plus" network
- Enter your City/State or Zip Code
- Click "Search" for a comprehensive directory of dentists
- Or, register for MetLife's mobile app at metlife.com/benefits to access you ID card, plan benefits and provider search.

METLIFE IS THE DENTAL CARRIER FOR 2022.

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding MetLife's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

What is Dental Insurance?

DENTAL INSURANCE PLAN OPTIONS & COSTS

METLIFE	Employee Cost Per Month Low Plan/High Plan	
Employee Employee+Spouse Employee+Child(ren) Employee + Family	$0 $27.50 $20.32 $58.14	$0 $49.96 $36.90 $105.66

	Low Plan	High Plan	
Deductible Individual / Family	$50/ $150	$25 / $75	Applied to Basic & Major Services
Annual Maximum	$1,000	$1,500	Applied to Type Basic & Major Services
	Carrier Pays In Network Low Plan/High Plan		
Diagnostic/Preventive Services	100%	100%	• Oral examinations & cleanings • Bitewing X-rays • Fluoride treatments (up to age 19) • Sealants (up to age 16)
Basic Services	70%	80%	• General anesthesia • Emergency palliative treatment • Fillings—amalgam and composite • Oral surgery—simple extractions • Oral surgery—ssurgical extractions • Other oral surgery • Endodontics • Periodontics
Major Services	50%	50%	• Bridges • Inlays/onlays/crowns • Dentures & implants • Prefabricated crowns • Repairs • Periodontal Surgery
Orthodontia Services	50% up to $1,000 lifetime maximum	50% up to $1,500 lifetime maximum	• Diagnostics & Treatment for children up to the age of 26

VISION INSURANCE

5 REVIEW YOUR VISION PLAN

FIND A PROVIDER

To find an EyeMed provider in your area, visit the website at eyemed.com

- Click on "Find an eye doctor"
- Select the "Insight Network" and enter your Zip Code
- Click "Search" for a comprehensive directory of vision providers

EYEMED IS THE VISION CARRIER FOR 2022.

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. The average Lasik discount is 15% off the regular price or 5% off the promotional price available at contracted facilities. To find a participating provider, go to eyemed.com.

VISION INSURANCE PLAN OPTIONS & COSTS

EYEMED	**Employee Cost Per Month**	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$0 $4.36 $4.86 $9.36	
	In-Network	**Out-of-Network**
Examination Copay	$20 copay	Reimbursement Up to $42
Frequency of Service Exam Lenses Frames	Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal Lenticular Standard Progressive	 $20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered $85 copay; 100% covered	Reimbursement Up to $40 Up to $60 Up to $80 Up to $80 Up to $60
Frames	$130 allowance, 20% off balance over $130	Reimbursement Up to $65
Conventional Contacts	$130 allowance 15% off balance over $130	Reimbursement Up to $105
Additional Discounts (In Network Only)	40% off additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used; 20% off non prescription sunglasses; 15% retail discount on Lasik.	

What is Vision Insurance?

LIFE/AD&D INSURANCE

6

REVIEW YOUR LIFE INSURANCE POLICY

- ☐ **Increase your coverage**
- ☐ **Add your spouse**
- ☐ **Add your dependents**

DID YOU KNOW?

The City of St. Charles School District provides you Basic Life and AD&D **AT NO CHARGE**

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

BASIC LIFE AND AD&D

The City of St. Charles School District provides all benefit eligible employees with Basic Life and Accidental Death & Dismemberment insurance.

This coverage is offered through Reliance Standard **at no cost to you.**

In the event of your death, your beneficiary will receive the amount of one times your annual earnings, rounded to the nearest thousand, in group life/AD&D insurance (maximum $250,000).

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

Dependent Life: This benefit, offered through Reliance Standard. Offers you two options. Option one provides $5,000 of coverage for your spouse and $2,500 for your children and the cost is $1.10 per month. Option two provides $10,000 of coverage for your spouse and $5,000 for your children and the cost is $2.10 per month.

Voluntary Life/AD&D and Voluntary Dependent Life/AD&D: You can purchase additional Life and AD&D Coverage beyond what the City of St. Charles School District provides. Reliance Standard guarantee issues coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history. Your Voluntary Life/AD&D benefits with Reliance Standard will reduce based on your age.

- **Voluntary Employee Life/AD&D:** minimum $10,000 to a maximum of $300,000. Guarantee issue up to $200,000.
- **Optional Spouse Life/AD&D:** minimum $5,000 up to 50% of the employee amount, to $150,000 maximum in $5,000 increments. Guarantee issue up to $25,000.
- **Optional Child(ren) Life/AD&D** for children 14 days to age 26 options of $5,000 or $10,000. Guarantee issue up to $10,000.

Travel Assistance: If you are enrolled in the Voluntary Life/AD&D plan you are automatically enrolled in Reliance Standard's Travel Assistance program.

24-Hour Travel Assistance

On Call International provided through Reliance Standard

In the U.S., toll free
(800) 456-3893

Worldwide, collect
(603) 328-1966

[What is Life and AD&D Insurance?]

Voluntary Life and AD&D Cost Per Month

	Rates per $1,000 of coverage	
Reliance Standard	**Age**	**Employe/Spouse**
Voluntary Life	<25	$0.05
	25-29	$0.04
	30-34	$0.05
	35-39	$0.06
	40-44	$0.10
	45-49	$0.15
	50-54	$0.26
	55-59	$0.45
	60-64	$0.62
	65-69	$1.09
	70-74	$2.24
	75+	$3.43
	Child(ren) life/AD&D	$0.23 / $0.02
Voluntary AD&D	$0.02	

If you and/or your dependents chose not to enroll in the Voluntary Life plan during your initial enrollment period you and/or your dependents will be required to complete an Evidence of Insurability form and be approved by Reliance Standard before you are able to obtain coverage in the future.

Annually, current enrolled employees can increase their election by up to $50,000 up to the guarantee issue without completing an Evidence of Insurability (EOI). Current enrolled spouses can increase their election by up to $10,000 up to the guarantee issue without completing an Evidence of Insurability (EOI). This applies to employees and spouses who have not been denied coverage in the past.

DISABILITY INSURANCE

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

7 REVIEW YOUR DISABILITY COVERAGE

- ☐ Voluntary Long-Term Disability
- ☐ Voluntary Short Term Disability

VOLUNTARY LONG-TERM DISABILITY

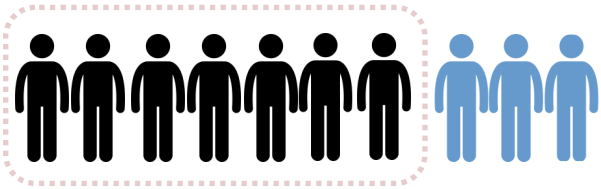
Voluntary Long-Term Disability insurance is offered through Reliance Standard. The plan benefit is 60% of salary to a maximum of $7,500 per month. The benefits begin after a 90 day waiting period. The premium for this plan is based on your age.

VOLUNTARY SHORT-TERM DISABILITY

Voluntary Short-Term Disability insurance is offered through Reliance Standard. Benefits begin paying an employee a disability benefit after a waiting period is satisfied and provides income protection to a maximum of $1,500 per week. You have the option of electing a 14 day or 30 day waiting period. A 3/12 pre-existing clause applies to this plan. This means if you were treated for a medical condition 3 months prior to your effective date, it will not be covered until you have been insured and still actively at work for 12 months.

Could you pay the bills if you weren't working?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

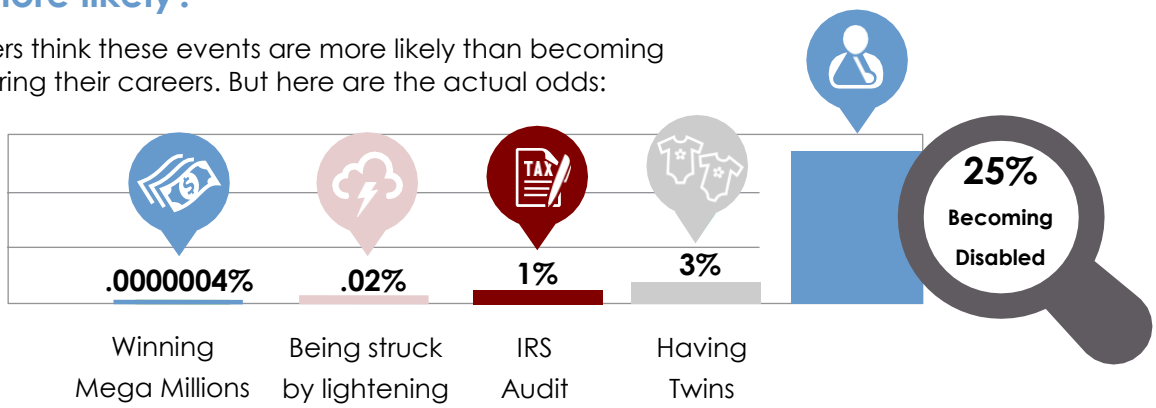


Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**

What is Disability Insurance?

What's more likely?

Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:



In fact, nearly **40 million** American adults live with a disability

VOLUNTARY COVERAGES

8

PROTECT YOUR FINANCES

- ☐ **Elect Critical Illness coverage**
- ☐ **Elect Accident insurance**
- ☐ **Elect Whole Life Insurance**
- ☐ **Elect Identity Theft Protection and Legal Assistance**

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances.

While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered—from deductibles and copays to living expenses.

This Critical Illness insurance policy from UNUM can help with the treatment costs of a covered critical illnesses—such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

[What is Critical Illness Insurance?]

GROUP CRITICAL ILLNESS COVERAGE INCLUDES:

- **Health Screening Benefit ($75)**
- **Critical Illness Benefit** payable for:
  - Cancer
  - Heart attack (myocardial infarction)
  - Stroke
  - Kidney failure (end-stage renal failure)
  - Major organ transplant
  - Bone marrow transplant (stem cell transplant)
  - Sudden cardiac arrest
  - Coronary artery bypass surgery
  - Non-invasive cancer
  - Skin cancer

FEATURES:

- Benefits are paid directly to you, unless you choose otherwise
- Coverage is available for you, your spouse, and dependent children
- You can take your coverage with you if you change jobs or retire (with certain stipulations)
- Fast claims payment (most claims are processed in about four days)

HOW CRITICAL ILLNESS COVERAGE WORKS

1. Critical Illness coverage is selected
2. You experience chest pains and numbness in your left arm
3. You visit the emergency room
4. A physician determines that you have suffered a heart attack
5. UNUM's Critical Illness coverage pays you a lump sum benefit

ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room—and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in.
In the event of a covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of.

UNUM ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches, and casts

BENEFITS INCLUDE:

- A Wellness Benefit of $75 for covered preventive screenings
- Transportation and Lodging Benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

FEATURES:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- Fast claims payment. Most claims are processed in about four business days

[What is Accident Insurance?]

WHOLE LIFE INSURANCE

You can keep Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. The benefit amount stays the same too. That means you get protection during your working years and into retirement.

Whole Life Insurance also builds cash value at a guaranteed rate of 4.5%. You can borrow from that cash value or you can buy a smaller, paid up policy with no more premiums due.

IDENTITY THEFT PROTECTION AND LEGAL ASSISTANCE PLAN

Identity Theft Protection

ID Shield is offered on a voluntary basis. The ID Shield membership includes these services:

- **Privacy monitoring**
- **Security monitoring**
- **Social media monitoring**
- **Credit monitoring**
- **Credit inquiry alerts**
- **Monthly credit score tracker**
- **Unlimited consultations**
- **ID Shield Vault (password manager)**
- **Full service restoration**

ID Shield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 26.

Legal Shield

With Legal Shield you will have access to a quality law firm 24/7 for covered personal situations. From real estate to speeding tickets to will preparation and beyond.

www.legalshield.com/info

Monthly Rates:

	ID Theft	Legal Shield	Both Plans
Individual	$4.48	$8.48	$12.95
Family	$9.48	$9.48	$16.95

EMPLOYEE ASSISTANCE

9 REVIEW THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

Mental health is an important part of overall health and wellbeing. If affects how we think, feel and act. It may also affect how we handle stress, relate to others and make decisions.

The EAP is a confidential service designed to help employees and families with personal or work/life balance concerns.

The EAP has a variety of professionals available to help you free yourself from personal worries at work.

Counselors are available 24 hours a day, 7 days a week at 855.75.4357 and rsli@acieap.com.

EMPLOYEE ASSISTANCE PROGRAM COVERAGE INCLUDES:

- ⇒ Stress Management
- ⇒ Depression/Anxiety/Panic Attacks
- ⇒ Elder Care Resources/Child Care Needs
- ⇒ Relationship/Family Concerns
- ⇒ Chemical Dependency
- ⇒ Eating Disorders
- ⇒ Domestic Violence
- ⇒ Grief or Loss
- ⇒ Financial Guidance
- ⇒ Nutritional Questions
- ⇒ Legal Guidance
- ⇒ Health Coaching Needs
- ⇒ Online Resources
- ⇒ 5 face to face counseling sessions

What is an Employee Assistance Program?

VIDEO LIBRARY

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- QHDHP vs. PPO
- QHDHP with HSA Overview

INSURANCE 101

- Benefits Key terms Explained
- How to Read an EOB
- What is a Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Health Savings Account?
- What is a Flexible Spending Account?
- My HSA Planner

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?

VOLUNTARY WORKSITE VIDEOS

- What is Accident Insurance?
- What is Critical Illness Insurance?

INSURANCE TERMS

Coinsurance—The plan's 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. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

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

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

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 copays are included in the out-of-pocket maximum.

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

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.

MEDICAL TERMS

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

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.

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

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

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

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from the City of St. Charles School District About Your Prescription Drug Coverage and Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UMR 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:

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.

The City of St. Charles School District has determined that the prescription drug coverage offered by the UMR health 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 City of St. Charles School District coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the City of St. Charles School District medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

This notice is a summary. For a full description of all of the City of St. Charles School District Benefit plans, please refer to the Summary Plan Descriptions.

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 the City of St. Charles School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of St. Charles School District. You also may request a copy of this notice at any time.

Contact: Lavenia Draper at 636.443.4001.

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

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

For more information about Medicare prescription drug coverage:

Visit http://www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	October 1, 2021
Name of Entity/Sender:	City of St. Charles School District
Contact:	Lavenia Draper / Director of Business Services
Address:	400 North Sixth Street, St. Charles, MO 63301
Phone Number:	636.443.4001

MEDICAID CHIP NOTICE

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

If you or your children are eligible for Medicaid or CHIP and you'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 January 31, 2021. Contact your State for more information on eligibility—

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, 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, Menu Option 4, Ext. 61565

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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, contact Lavenia Draper at (636) 447.4001.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C by March 2, 2021. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

The City of St. Charles School District has amended the Medical, Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

NOTICE OF PRIVACY PRACTICES

The City of St. Charles School District is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

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.

NOTICE REGARDING WELLNESS PROGRAM

City of St. Charles School District's Wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Lavenia Draper at 636.443.4001.

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Lavenia Draper at 636.443.4001.

MARKETPLACE COVERAGE OPTIONS *[FOR NEW HIRES ONLY]*

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. [1]

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the City of St. Charles School District's Benefits Department.

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.

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1 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% of such costs.

MARKETPLACE COVERAGE OPTIONS (CONT.)

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.

Employer Name: The City of St. Charles School District	**Employer Identification Number (EIN):** 43-6003128
Employer Address: 400 North Sixth Street St. Charles, MO 63301	**Employer Phone Number:** 636.443.4047
Who can we contact about employee health coverage at this job? Lavenia Draper	**Phone Number:** 636.443.4001 **Email Address:** ldraper@stcharlessd.org

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

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

All employees. Eligible employees are:

X Full time employees, working a minimum of 30 hours week on a regular basis. Employees will be effective on their date of hire.

☐ Some employees. Eligible employees are:

- With respect to dependents:

X We do offer coverage. Eligible dependents are defined in the UMR Summary Plan Description.

☐ We do not offer coverage.

X 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.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

NOTES

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