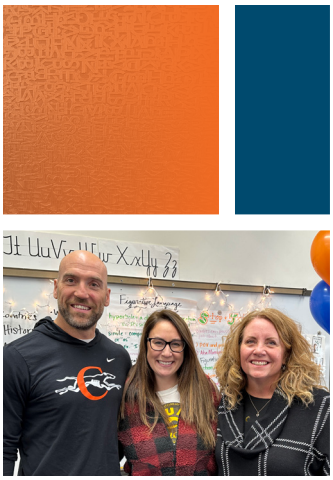
THE SCHOOL DISTRICT OF CLAYTON

2024 Benefits Guide Retiree



Helping You Become a Better You.

Contact Information & Table of Contents

CONTACTS

The School District of Clayton in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or call the Business Office at 314-854-6024.

Medical

Anthem
Group Number: W60496
anthem.com
800.490.6145

Dental

Guardian Dental
Group Number: 00025763
guardiananytime.com
888.600.1600

Cigna DHMO
Group Number: 10050105
Cigna.com
800.244.6224

Vision

EyeMed
Group Number: 1018839
eyemed.com
866.939.3633

CBIZ Consultant

Eric File
efile@cbiz.com
314.692.5848

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RETIREE BENEFIT NEWSLETTER

The School District of Clayton is getting ready for the 2024 benefit year which begins on January 1, 2024. The District's benefit package will continue to offer Medical, Dental and Vision benefit plans.

Benefits Offered

- **Three medical** plans administered by Anthem: a Base Plan, Buy-Up Plan, and a Qualified High Deductible Health Plan (QHDHP).
- Each medical plan offers a choice of either the Blue Access Choice full network which includes the BJC provider network or the Blue Preferred Select narrow network which does not include the BJC provider network. The District offers several plans at no cost to the employee.
- **Two dental plans—**one is offered through Guardian Dental and the other through Cigna DHMO.
- **Vision** plan through Eyemed.

A brief summary of all our benefit plans along with rates based upon the coverage you select are provided in this newsletter.

Open enrollment begins on October 23, 2023 and ends on November 3, 2023.

John Brazeal
Chief Financial Officer

YOUR CURRENT BENEFIT ELECTIONS WILL ROLL OVER TO 2024, EFFECTIVE JANUARY 1, 2024. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT CHERYL REDOHL AT 314-854-6024.

What's Inside?

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

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.

Medical Plans

Below is a summary of the three medical plan options available beginning January 1, 2024. **It is to your advantage to use in-network providers.** If you go out-of-network, you will be responsible for any amount exceeding Anthem's negotiated discounts plus any deductible and co-insurance associated with your procedure.

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

Plan Designs - Administered by Anthem

Features	Base Plan	Buy-Up Plan	Qualified High Deductible Health Plan*
In-Network Deductible ***(per calendar year)*** (Individual / Family)	$750/$1,500	$300/$600	$3,200 / $6,400 (Embedded)
Deductible is Calendar Year			
Out-of-Pocket Maximum *(per calendar year)* *(includes deductibles & copays - RX copays do not apply for Base and High Plans)* (Individual / Family)	$3,500/$7,000	$3,000/$6,000	$4,000/$8,000
Coinsurance *(the amount the plan pays)*	80%	90%	90%
Office Visits (Preventive—100% in-network)	$30 Primary Care Physician $60 Specialist	$25 Primary Care Physician $50 Specialist	Deductible & Coinsurance
LiveHealth Online	$30 Copay	$25 Copay	$49 Copay after deductible
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Lab, X-Ray and Diagnostic	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	$50 Copay	$50 Co-Pay	Deductible & Coinsurance
Emergency Room	$300 Copay	$200 Co-Pay	Deductible & Coinsurance
Prescription Drug (Ingenio Rx) Retail Pharmacy Mail Order Pharmacy	$10 / $40 / $70 / $150 2 Copays	$10 / $40 / $70 / $150 2 Copays	Deductible & Coinsurance Deductible & Coinsurance

*If you elect to enroll in the Qualified High Deductible Health Plan (QHDHP), you have the option to enroll in the Health Savings Account.

The School District of Clayton offers retirees the ability to choose between two network options for each medical plan.

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

Medical Plan Network Options

Medical Plan Network Options

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

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

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

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

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

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

Monthly Medical Retiree Cost

Coverage Type	Base Plan		Buy-Up Plan		QHDHP	
	Full Network	Narrow Network	Full Network	Narrow Network	Full Network	Narrow Network
Retiree	$800.00	$800.00	$965.00	$917.00	$675.00	$675.00
Retiree/Spouse	$1,472.00	$1,384.00	$1,785.00	$1,696.00	$1,115.00	$1,048.00
Retiree/Children	$1,328.00	$1,248.00	$1,612.00	$1,531.00	$995.00	$935.00
Family	$2,072.00	$1,948.00	$2,509.00	$2,384.00	$1,619.00	$1,522.00

Health Savings Account (HSA)

What is an HSA?

A savings account set up by you where you can deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours to spend on eligible healthcare costs. The HSA is held in your name, just like a personal checking or savings account.

What Rules Must I Follow?

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

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

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

If you or your family have high prescription costs, you may want to consider the Base or Buy Up plan over the QHDHP to help cover those expenses.

What Else Do I Need to Know?

	2024 Total Annual Maximum Contribution
Employee	$4,150
Employee + Family	$8,300

- The IRS sets HSA contribution limits yearly, which are listed under "Total Annual Maximum Contribution" in the table below. You cannot put more than this amount in the account in a calendar year; you can put less.
- HSA contributions are tax-free as long as you utilize the funds for approved services (medical, dental, vision and over-the-counter medically necessary items).
- Your unspent contributions roll over from year to year.
- If you use HSA money for non-qualified expenses, that money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other than eligible medical purposes without paying the 20% penalty, but you will pay income taxes.

Dental Insurance—Guardian Dental PPO

Facts and tips

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

To find a participating dentist, visit www.guardianananytime.com. The list of available dentists is not guaranteed and it is advisable to ask your dentist if they are currently participating or accepting new patients. Although the Guardian Dental plan allows you the freedom to visit any licensed dentist, you will save more on your out-of-pocket costs when you visit a Guardian PPO dentist. The Guardian Platinum network also provides cost saving features and is the next best option. Ask your dentist if they are a Guardian Platinum or Gold/Silver provider to choose the plan that's right for you. The dentist you choose could affect your cost.

Plan Design - Administered by Guardian Dental of Missouri

Features	Platinum	Gold/Silver	Non Contracted
Deductible *(Calendar Year)* (Individual / Family)	$50 / $150	$50 / $150	$50 / $150
Type I - Preventive Care: (Exams, Cleanings, X-rays)	100% (No Ded.)	100% (No Ded.)	100% (No Ded.)
Type II—Basic Procedures: (Fillings, Extractions)	90%	80%	80%
Type III—Major Procedures: (Caps, Crowns, Bridges, Dentures)	60%	50%	50%
Endodontics:	90%	80%	80%
Periodontics:	90%	80%	80%
Type IV—Orthodontia: (dependent children under age 19)	50% to $2,000 Lifetime Maximum	50% to $2,000 Lifetime Maximum	50% to $2,000 Lifetime Maximum
Maximum Benefits/Year	$2,000	$2,000	$2,000

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

Monthly Dental Retiree Cost

Coverage Type	
Retiree	$ 41.72
Retiree/Spouse	$ 83.44
Retiree/Children	$101.74
Family	$143.51

Dental Insurance—Cigna DHMO

Facts and tips

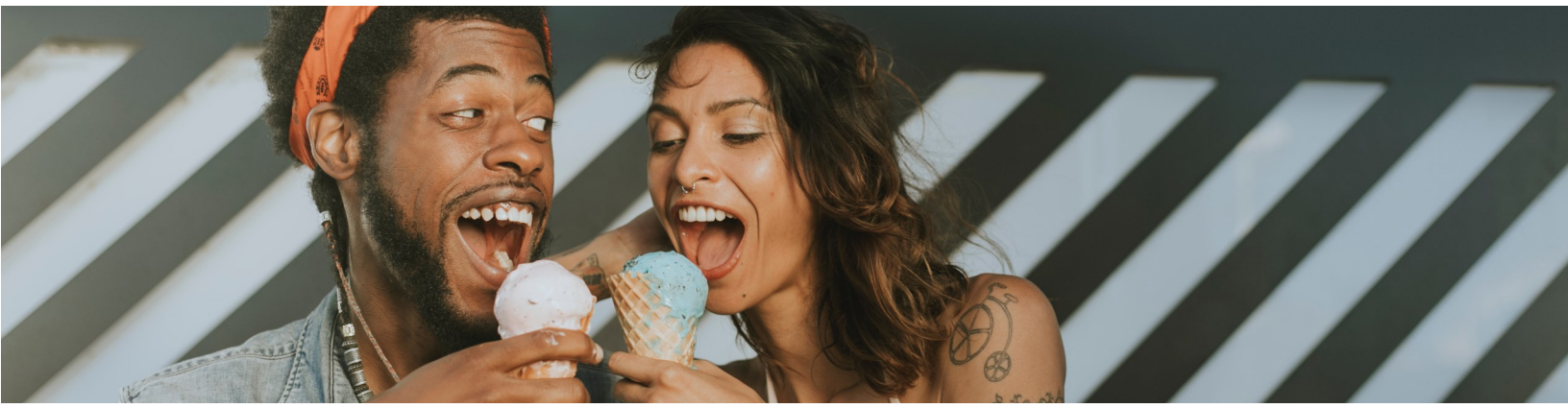
- You are responsible for a **$5 office visit** fee per patient, per office visit.
- You have to be on the dentist's roster in order to receive treatment.
- Check the **Patient Charge Schedule K1-V9** before receiving services to know your responsibility.
- The Patient Charge Schedule K1-V9 is located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

Monthly Dental Retiree Cost

Coverage Type	
Retiree	$27.34
Retiree & Spouse	$47.91
Retiree & Child(ren)	$50.70
Family	$76.84

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

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



Vision Insurance—EyeMed

Please notice out-of-network services only provide a reimbursement benefit. You will have to pay for services first then file a claim with EyeMed.

Plan Design - Administered by EyeMed

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

Facts and tips

Frequency of Service:
Exam: Every 12 months
Lenses: Every 12 months
Frames: Every 24 months

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

Monthly Vision Retiree Cost

Coverage Type	
Retiree	$ 6.82
Retiree & Spouse	$12.96
Retiree & Child(ren)	$13.64
Family	$20.06

Anthem Health & Wellness Resources

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

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

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

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

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

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

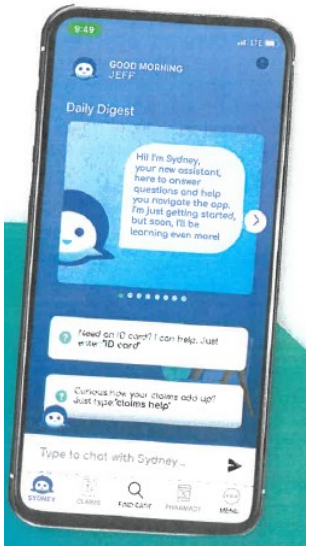
ConditionCare. Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your goals based on your doctor's plan. You can work with dietitians, health educators,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

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

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

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

Anthem Health & Wellness Resources (con't)



Get Started with Sydney.

To download the app:

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

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

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

ENROLLMENT

How to Enroll

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

EMBBenefits.com/clayton

Enroll in the Online system

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

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

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

Self-Service

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

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

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

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact the Business Office at extension 6024.

Women's Health and Cancer Rights Act of 1998

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

Newborns' and Mothers' Health Protection Act

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

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

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

COBRA Continuation Rights Under Federal Law

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage plus a 2% administrative fee. Please contact the School District of Clayton's Business Office for additional information.

Important Notices cont.

Notice of Privacy Practices

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

Marketplace Options

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance, which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit, which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 through January 15, 2024.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer, which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

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

Medicaid CHIP Notice

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Important Notices cont.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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

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

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

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

Medicare Part D Creditable Coverage

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

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

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

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

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

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

This information is provided for the Medicare open enrollment period, which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227)

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

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Privacy Notice Regarding Wellness Programs

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

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

Incentives may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the School District of Clayton's Business Office.

Protections from Disclosure of Medical Information

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

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

Important Notices cont.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Human Resources Department.

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Benefit Guide Description

This summary of benefits is not intended to be a complete description of the School District of Clayton's insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan.

In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although the School District of Clayton maintains its benefit plans on an ongoing basis, the School District of Clayton reserves the right to terminate or amend each plan in its entirety or in any part at any time.

For questions regarding the information provided in this overview, please contact your Business Office representative.