PARKWAY SCHOOLS

HIGHER EXPECTATIONS. BRIGHTER FUTURES.

2017 Employee Benefits Guide

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

TABLE OF CONTENT

2017 RENEWAL HIGHLIGHTS

- There has been **no change to the payroll deductions for all of our UnitedHealthcare medical plans.** This is the second year in a row where employees enrolled in the Base plan and QHDHP will not experience a rate increase.
  Additionally, there have been no plan changes made to the UnitedHealthcare Medical plans. Deductibles and copays will remain the same as they were in 2016. Please look at pages 6-8 for more information on all of our medical plans.
- Voluntary life insurance coverage of up to $200,000 can be elected during open enrollment. Spousal coverage of up to $50,000 and dependent coverage of up to $10,000 can also be elected. There is a one-time special enrollment opportunity for the Voluntary Life/AD&D program. During this special enrollment, employees can purchase life insurance for themselves and their family up to specified limits without having to complete a medical questionnaire.
- The Delta Dental calendar year maximum has been increased to $1,250 per person from $1,000 per person while dental rates are only increasing $1.09 per check for the highest level of dental coverage.
- The Vision plan carrier has changed to EyeMed allowing for an enhanced Vision program while rates are only increasing by less than a quarter per check. For more information on the improved vision plan please look at page 10.
- The District is using a new open enrollment software, SmartBen, that is easier to use. The new software will also allow you to sign up for more benefits than could be selected in the past. Please visit page 3 for more information on the new software.
- The pharmacy benefit manager on the Qualified High Deductible Health Plan (QHDDP) has changed to Express Scripts from Optum Rx. Currently Express Scripts is the prescription provider for the Base and Premium plans. If you enrolled in the QHDHP there may be a change to the cost of your current prescriptions. As well, if you are on a specialty medication Express Scripts will allow a one month fill of the medication at a pharmacy before you will be required to fill the specialty mediation through mail order (Accredo). You do NOT have to obtain a 3 month supply of your medication through the mail order program. You can purchase one month supply if you choose to.
- The Basic Life plan, provided at no cost to you, will now include an Accidental Death and Dismemberment benefit.
- The Employee Assistance Plan (EAP) has been enhanced to include five face to face counseling visits. Unlimited telephonic counseling is still included.
- The District will continue to contribute a time lump sum payment of $520 into the HSA with the first payroll in January and $40 per payroll thereafter for an annual total of $1,440 if you are enrolled in the QHDHP.
- Employees can sign up for a 403 or 457 plan year round. You can also change your contributions throughout the year. Please visit the benefits page for more information on the plans or go to **http://www.pkwy.k12.mo.us/inside/benefits/health/Sign_Up_instructions.pdf** to see the simple sign-up steps to start a 403 or 457 plan.

CONTACT INFORMATION

Vendors		
Medical: *UnitedHealthcare (Base and Premium Plans)* Group Number: 716393 **Pharmacy:** *Express Scripts (Base and Premium Plans)* Group Number: DU2	866.633.2474 866.854.2169	www.myuhc.com www.express-scripts.com
Medical: *United Healthcare (High Deductible) & Optum Bank* Group Number: 716393 **Pharmacy:** *Express Scripts (High Deductible Plan)* Group Number: DU2	866.734.7670 **Optum Bank Member Services:** 800.791.9361 (Option 1) 866.854.2169	www.myuhc.com www.optumhealthbank.com www.express-scripts.com
Dental: *Delta Dental* (PPO) Group Number: 1527-1000 **Dental:** *Assurant** (Pre-Paid) **not open to new enrollees for 2017* Group Number: 000AD04	800.335.8266 or 314.656.3001 (Delta Dental) 800.443.2995 (Assurant)	www.deltadentalmo.com www.assurantemployeebenefits.com
Vision: *EyeMed* Group Number: 1006768	866.939.3633	www.eyemedvisioncare.com
Life/AD&D & Voluntary Term Life and AD&D: *AIG* Group Number: P94A21	800.221.3480	www.aigbenefits.com
Advodate4Me: *UnitedHealthcare* Group Number: 716393	Call Number on Back of Medical ID Card	www.myuhc.com
Virtual Visits: *UnitedHealthcare* Group Number: 716393		www.myuhc.com
Employee Assistance Program (EAP): *AIG*	888.673.1149	www.aigbenefits.com/eap **Username:** aig **Password:** eap
Benefits Team	**Phone**	**Email**
Parkway School District: *Tammie Newman* *Janet Bova Conti* *Brian Whittle*	314.415.8058 314.415.8059 314.415.8060	tnewman@parkwayschools.net jbovaconti@parkwayschools.net bwhittle@parkwayschools.net
CBIZ Benefits & Insurance Services: *Eric File or Asha Kuhn*	314.692.2249 or 800.844.4510	akuhn@cbiz.com efile@cbiz.com

Reasons to Call and Who to Call:

Claim Questions—Contact Carrier / CBIZ
Provider Search—Carrier Websites
I.D. Cards / Numbers—Contact Carrier / CBIZ
If Drug Prescription is Denied—Provider / Doctor

OPEN ENROLLMENT

SmartBen is our new online enrollment tool.

The site is accessible via the Internet at https://www.benefitslive.com/sso/singlesignon/?siteId=2101 and can be accessed 24 hours a day, seven days a week. The following will help you prepare for and complete the online enrollment process.

Your open enrollment period for the 2017 calendar year for health benefits is scheduled to begin **November 1, 2016** and conclude **November 30, 2016**. All changes must be received at Parkway by 4:00 p.m. on **November 30, 2016**.

REQUIRED

ALL EMPLOYEES will need to enroll to make your benefits elections (plan and/or coverage level). If you do not enroll, your Medical, Dental, Vision, and Voluntary Life & AD&D insurance elections will be reset to the default of Waive coverage.

Before You Enroll....

Take time to review the information in the Plans section. It will help you understand your benefit choices. Discuss it with your family, too!

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

How to Enroll ....

Log on to https://www.benefitslive.com/sso/singlesignon/?siteId=2101 A direct link for this site is also available on Inside Parkway on the Benefits Page. Next click "Login with Parkway School District." Your Username (**pkwy**\ then your username) and Password (your District password). This should be the sign-in you use to log into a District computer or Workforce.

Example Username:
pkwy\jdoe3 or pkwy\jsmith

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

Example
ljames2@pkwy.k12.mo.us

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

For full instructions, go to...

http://www.pkwy.k12.mo.us/inside/benefits/health/2017_Annual_Enrollment_Instructions.pdf

Employee Cost Calculator

An **Employee Cost Calculator** is available to help you determine which plan is the best fit for you and your family. This tool will compare the cost of the three medical plans and help determine the most beneficial plan for you. This tool can be found on the Parkway School District's website under ***Benefits Page.***

Health Care Coverage Options:

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

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

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

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

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

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

  These subsidies are designed for people who earn between 100 percent and 400 percent of the Federal Poverty Line, or about $23,850–$95,400 for a family of four or $11,670–$46,680 for an individual. If an employee's income is under these limits, it will probably be more cost effective to purchase a new policy and receive the subsidies to help pay the premium.

Why is CBIZ SelectQuote Being Offered?

SelectQuote Benefit Solutions, through its partner CBIZ, will help you understand your choices and guide you through the options related to healthcare coverage to help you find a plan that best suits your needs. This service available to anyone seeking additional health care options and there is no additional cost associated with this service.

Keeping Your Health Care Affordable

As the healthcare marketplace evolves, we are committed to providing you access to affordable, high quality healthcare options. Get started today to make the most of this benefit for you and your family.

Getting Started

Review your options at cbiz.selectquotebenefits.com or call at 1.855.801.5742.

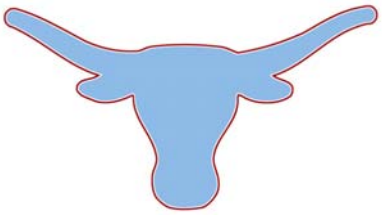
CHANGING COVERAGE DURING THE YEAR

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

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

If you wish to change your election, you must contact the Benefits Department within <u>30</u> days of the change in family status. You will need to provide documentation of the change. Otherwise, you will need to wait until the next annual open enrollment






MEDICAL INSURANCE OPTIONS

UnitedHealthcare - Base Plan

Benefit Plan	In-Network	Out-of-Network
Deductible	$650 / Single	$2,000 / Single
Coinsurance	10%	40%
Out-of-Pocket Maximum (includes deductible, coinsurance and copays with the exception of prescription copays)	$2,000 / Single $4,000 / Family	$4,000 / Single $8,000 / Family
Physician Office Visit	$25 Primary Care $50 Specialist	Deductible, then you pay 40%
Preventive Care (includes office visit & certain tests associated with preventive care)	100% Covered Deductible Does Not Apply	Deductible, then you pay 40%
Inpatient Hospital & Outpatient Surgery	Deductible, then you pay 10%	Deductible, then you pay 40%
Diagnostic Lab, X-Ray and Other Tests	Deductible, then you pay 10%	Deductible, then you pay 40%
Emergency Room	$200 Copay	$200 Copay
Urgent Care Center	$75 Copay	Deductible, then you pay 40%
Prescription Drug Coverage (through Express Scripts; $4,500 out-of-pocket maximum)		
Retail Pharmacy Copay	$12 / $40 / $60	Not Available
Mail Order Pharmacy	2 Times Copay	Not Available
90 Day Retail Copay	$36 / $120 / $180	Not Available

EMPLOYEE COST		
Type of Coverage	**Monthly Cost 2016**	**Monthly Cost 2017**
Employee Only	$0	$0
Employee & Spouse	$240	$240
Employee & Spouse + 1	$350	$350
Employee & Spouse + 2	$490	$490
Employee & Children (1)	$120	$120
Employee & Children (2)	$240	$240

PLAN HIGHLIGHTS

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

UnitedHealthcare - Premium Plan

Benefit Plan	In-Network	Out-of-Network
Deductible	$500 / Single $1,000/ Family	$1,000 / Single $2,000 / Family
Coinsurance	0%	30%
Out-of-Pocket Maximum (includes deductible, coinsurance and copays with the exception of prescription copays)	$1,500 / Single $3,000 / Family	$4,000 / Single $8,000 / Family
Physician Office Visit	$20 Primary Care $30 Specialist	Deductible, then you pay 40%
Preventive Care (includes office visit & certain tests associated with preventive care)	100% Covered Deductible Does Not Apply	Deductible, then you pay 40%
Inpatient Hospital & Outpatient Surgery	Deductible Applies	Deductible, then you pay 40%
Diagnostic Lab, X-Ray and Other Tests	Deductible Applies	Deductible, then you pay 40%
Emergency Room	$150 Copay	$150 Copay
Urgent Care Center	$50 Copay	Deductible, then you pay 40%
Prescription Drug Coverage (through Express Scripts; $4,500 out-of-pocket maximum)		
Retail Pharmacy Copay	$12 / $35 / $55	Not Available
Mail Order Pharmacy	2 Times Copay	Not Available
90 Day Retail Copay	$36 / $105 / $165	Not Available

EMPLOYEE COST		
Type of Coverage	**Monthly Cost 2016**	**Monthly Cost 2017**
Employee Only	$90	$90
Employee & Spouse	$470	$470
Employee & Spouse + 1	$680	$680
Employee & Spouse + 2	$860	$860
Employee & Children (1)	$310	$310
Employee & Children (2)	$490	$490

PLAN HIGHLIGHTS

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

UnitedHealthcare - Qualified High Deductible Health Plan (QHDHP) with HSA

Benefit Plan	In-Network	Out-of-Network
Deductible **(embedded)**	$2,600 / Single $5,200/ Family	$5,000 / Single $10,000 / Family
Coinsurance	0%	30%
Out-of-Pocket Maximum (includes deductible and coinsurance	$2,600 / Single $5,200 / Family	$8,000 / Single $16,000 / Family
Physician Office Visit	Deductible Applies	Deductible, then you pay 30%
Preventive Care (includes office visit & certain tests	100% Covered	Deductible, then you pay 30%
Inpatient Hospital & Outpatient Surgery	Deductible Applies	Deductible, then you pay 30%
Diagnostic Lab, X-Ray and Other Tests	Deductible Applies	Deductible, then you pay 30%
Emergency Room	Deductible Applies	Same as In Network
Urgent Care Center	Deductible Applies	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy Copay	Deductible Applies	Deductible, then you pay 30%
Mail Order Pharmacy	Deductible Applies	Deductible, then you pay 30%

EMPLOYEE COST		
Type of Coverage	**Monthly Cost 2016**	**Monthly Cost 2017**
Employee Only	$0	$0
Employee & Spouse	$130	$130
Employee & Spouse + 1	$250	$250
Employee & Spouse + 2	$370	$370
Employee & Children (1)	$70	$70
Employee & Children (2)	$150	$150

PLAN HIGHLIGHTS

- If you elect the QHDHP, you may also participate in a Health Savings Account (HSA). Details of the HSA are on the following pages. The District contributes **a one time lump sum payment of $520 into the HSA with the first payroll in January and $40 per payroll thereafter for an annual total of $1,440!**
- With an embedded deductible, the health plan begins to make payments as soon as one member of the family has reached the individual deductible limit. For example, if an individual in your family reaches the $2,600 deductible limit all of his/her in network claims for the remainder of the calendar year will be covered even though the family deductible of $5,200 has not been met.
- Prescription Drug Benefit through Express Scripts .
- The employee cost is covered by District.
- Dependents are covered until 26 (end of month).

DENTAL INSURANCE

Our dental benefit carriers are Delta Dental and Assurant Dental (grandfathered plan). The Delta Dental plan offers three network options for your dental care. If you utilize the PPO Network, you will receive the advantage of contracted fees negotiated between Delta Dental and the dentist. Your second option is the Premier Network. A dentist in the Premier Network accepts fees offered by Delta Dental under a contractual agreement and will not balance bill. Finally, if you elect an out of network dentist, benefits are paid based on Delta's maximum allowance. You may experience balance billing and higher out-of-pocket expenses if you utilize a Non-Network dentist. The Assurant Dental plan offers a copay type plan for in network services only. Dependents are covered until 26 (end of month) on both plans.

Delta Dental

Benefit	PPO Network You Pay	Premier Network You Pay	Non-Network You Pay
Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Deductible Applies To:	Basic & Major	Basic & Major	Basic & Major
Coinsurance			
Preventive	0%	0%	0%
Basic Services	20%	25%	25%
Major Services	40%	45%	45%
Periodontics	20%	25%	25%
Endodontics (Root Canal)	20%	25%	25%
Oral Surgery	40%	45%	45%
Annual Maximum	$1,250 Per Person Max. Advantage is included—charges for preventive services do not apply towards the annual maximum		
Orthodontia Adult and Child to age 26	40%	40%	40%
Lifetime Maximum	$1,000 per member		

Assurant Dental (closed to new enrollees)

Benefit	PPO Network
Deductible	
Individual	$0
Family	$0
Schedule*	
Preventive	Scheduled Copayment
Basic Services	Scheduled Copayment
Major Services *see plan summary for full details	Scheduled Copayment
Periodontics	Scheduled Copayment
Endodontics (Root Canal)	Scheduled Copayment
Oral Surgery	Scheduled Copayment
Annual Maximum	Unlimited Per Person
Orthodontia	Discounts Available

Delta Dental - Employee Contribution

Type of Coverage	Monthly EE Cost
Employee Only	$0
Employee & Spouse	$17.98
Employee & Spouse & 1 or more Child (ren)	$45.78
Employee & 1+ Child	$27.80

Assurant - Employee Contribution

Type of Coverage	Monthly EE Cost
Employee Only	$0
Employee & 1 Dependent*	$4.32
Employee & 2 Dependents*	$10.42

VISION INSURANCE

EyeMed is the vision carrier for 2017. The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider to take advantage of the established contract rates and benefits. If you go out-of-network, your benefit is based on a reimbursement schedule. Also, if you are considering Lasik Surgery, there is a discount available with particular providers. **You will now receive an ID card if you elect the Vision coverage.**

EyeMed (New Vendor)

Benefit	In-Network	Non-Network
Exam Copay	Covered 100%	$40 Reimbursement
Frequency		
Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	
Lenses	$20 co-pay then	Reimbursement
Single	100%	$31
Lined Bifocal	100%	$51
Lined Trifocal	100%	$64
Lenticular	100%	$80
Standard Progressive	$85 co-pay	$65
2-Year Scratch Protection	100%	N/A
UV 400	100%	N/A
Solid or Gradient Lens Tints	100%	N/A
Polycarbonate Lens Material	100%	N/A
Frames**	$130 allowance plus 20% off remaining balance	$65
Contacts		
Necessary	100%	$210
Cosmetic	$130 plus 15% off balance	$104
Laser Vision Correction	Discount Available	N/A

	Monthly EE Cost
Employee Only	$0
Employee & 1 Dependent	$2.06
Employee & Family	$4.00

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

FIND A PROVIDER

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

- **Click "Find a Provider" at the top right of the webpage**
- **Enter your zip code, select the *Insight* Network and hit the "Get Results" button**
- **The search will generate a report of the Search Results, listing the providers closest to your zip code first**
- **You can refine your search even more under the "Filter Search Results" on the left side of the webpage.**
- **OR, you can call 866.939.3633 to speak with a Customer Service representative**

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

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

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

LIFE INSURANCE AND AD&D INSURANCE

The Basic Life/Accidental Death & Dismemberment benefit provided by the District will remain the same. This benefit is provided at no cost to eligible employees and will now be administered by AIG. Included with this benefit, at no cost to you, is travel assistance services. This is a 24-hour, toll free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medial care situations and many other emergencies you many encounter when you travel. The toll free number is 1-877-244-6871.

VOLUNTARY TERM LIFE AND AD&D INSURANCE

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

You must purchase supplemental life/AD&D on yourself in order to purchase coverage for your spouse and/or dependent children. Benefit reductions apply upon attaining certain age levels. Most employees have coverage available in the amounts of $25,000, $50,000, $100,000, $150,000 or $200,000. The guarantee issue for most employees is $200,0000. Spousal coverage is available in amounts of $10,000, $15,000, 25,000 or $50,000. The guarantee issue for the spouse is $50,000. Child(ren) coverage is available from live birth to 26 years of age and your choice of $5,000 or $10,000.

You and your dependents will have a one time special enrollment opportunity during this open enrollment period to purchase additional life/AD&D insurance without having to complete a medical questionnaire (EOI) up to the Guarantee Issue limits.

If you and/or your dependents do not enroll during this initial enrollment period in the Voluntary Term Life and AD&D plan you will be required to complete an Evidence of Insurability (EOI) form and be approved by AIG before you are able to obtain coverage in the future.

EMPLOYEE LIFE/AD&D (Monthly Rate per $1,000)	
Age	**Rate**
<25	$0.076
25-29	$0.076
30-34	$0.076
34-39	$0.096
40-44	$0.146
45-49	$0.206
50-54	$0.306
55-59	$0.466
60-64	$0.696
65-69	$1.086
70-74	$1.646
75-79	$2.846
80+	$2.846
SPOUSE LIFE (Monthly Rate per $1,000)	
<25 - 80+	$.332
DEPENDENT LIFE RATE (Monthly Rate per $1,000)	
Child(ren)	$0.180

FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care FSA

The Health Care Flexible Spending Account is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans. By contributing a portion of your payroll dollars into your Flexible Spending Account on a pre-tax basis, you can save from 25% to 40% on the cost of eligible expenses you are already incurring.

When you enroll in a Flexible Spending Account, you decide how much to contribute to each account for the entire Plan

Year. The money is then deducted from your paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts over the course of the plan year. After you incur expenses that qualify for reimbursement, you submit claims (reimbursement requests) to UHC to request tax-free withdrawals from your Flexible Spending Account to reimburse yourself for these expenses.

The key to getting the most out of your Health Care Flexible Spending Account is to maximize your contributions based on the expenses you, or any of your tax dependents, anticipate incurring during the plan year.

Plan your annual election amount…..

Review

The list of Eligible Expenses, which can be found at www.myuhc.com and your medical expenses from last year.

Estimate

Any additional eligible expenses you anticipate incurring in the coming plan year. Include at least some money to cover your deductible expenditures.

Your cost for each of these Flexible Spending Account eligible expenses. (Don't forget that your tax dependents' expenses qualify, too, even if they are on a different health insurance program.)

Things to remember about the Health Care Flexible Spending Account…..

Your election amount is typically fixed for the entire plan year (unless you have a qualifying event)

You must submit valid claims before the end of the claims run out period. Any unclaimed remaining funds will be forfeited to your employer, so estimate your expenses carefully and set money aside accordingly.

Expenses for any of your tax dependents are eligible for reimbursement, even if they are not on your employer's health insurance program.

Dependent Care FSA

Dependent Care Flexible Spending Accounts create a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. Additionally, if you have an older dependent who lives with you at least 8 hours per day and requires someone to come into the house to assist with day-to-day living, you can claim these expenses through your Dependent Care Flexible Spending Account. If you are married, your spouse must be working, looking for work or be a full-time student. **If you have a stay-at-home spouse, you should not enroll in the Dependent Care Flexible Spending Account**. The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care Flexible Spending Account in a calendar year.

Please note that IRS regulations disallow reimbursement for services that have not yet been provided, so even if you pay in advance for your expenses, you can only claim service periods that have already occurred. For example, if you are required to pay for all of January's child care expenses on January 1st, you cannot claim the entire month's expense until the end of January. However, you may submit a claim every week, at the end of that week, for those expenses.

Eligible expenses include day care, baby-sitting, and general purpose day camps.

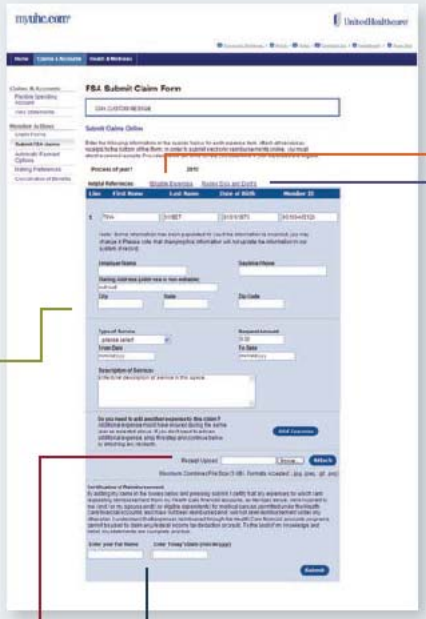
Ineligible expenses include overnight camps, care provided by a dependent, your spouse or your child under the age of 19 & care provided while you are not at work. Expenses may only be claimed for dependents that are under the age of 13; or for older dependents that live with you at least 8 hours each day and are incapable of self-care.

IF YOU ELECT DEPENDENT DAY CARE PRE-TAX DEDUCTIONS AND YOU DO NOT HAVE ELIGIBLE DEPENDENTS YOU WILL LOSE ANY AMOUNT DEDUCTED FROM YOUR PAYCHECK FOR THIS BENEFIT. THE DEDUCTION CAN BE STOPPED UPON REQUEST, BUT YOU WILL NOT BE ABLE TO RECOUP WHAT WAS DEDUCTED.

Remember that your election is fixed for the entire year unless you have a qualifying event.

Online Claim Submission

Log in to myuhc.com® and submit claims for your UnitedHealthcare Flexible Spending Account or Health Reimbursement Account



1

Submit multiple claims

You can submit multiple FSA/HRA claims and receipts for multiple members of the family all at once.

2

Pre-filled information

The following fields will be automatically populated from your profile:

- Last name
- First name
- Member ID
- Date of birth
- Employer name
- Mailing address
- Daytime phone number

3

Eligible Expenses

View the list of eligible expenses.

4

Helpful information

View helpful information such as *Do's and Don'ts* on the claim form hub page and while filling out the claim form.

5

Upload receipts

Upload multiple attachments (receipts, etc.) while filling out and submitting the online form.

6

Sign your submission

Read the "Certification for Reimbursement" and electronically sign the claim form before submitting.

7

Confirmation

You'll receive confirmation upon submitting the online form and be able to print your submitted claim form and confirmation.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Parkway has an Employee Assistance Program at no cost to our employees. This benefit is through AIG and offers confidential, short-term counseling for personal and family issues at no cost to you. Your communications with the EAP are always confidential.

Program Features…..

- Work-Life Services
- Legal and Financial Counseling
- Identity Theft
- Tax Consultation
- Child and Elder Care Consultation
- Will Prep
- Legal Document Prep
- Funeral Prep
- Bereavement Convenience and Daily Living Resources
- Employee Discounts
- Life Coach
  - Weight management
  - Physical activity
  - Healthy eating
  - Tobacco cessation
  - Chronic medical condition management

Bonus Features

Access to master's and doctoral-level counselors

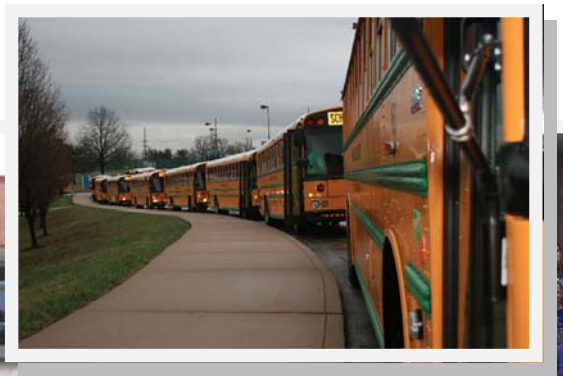
5 face-to-face sessions

Getting Assistance

888.673.1149

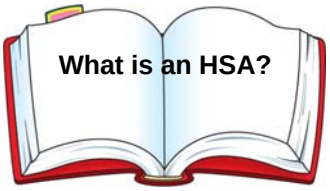
aigbenefits.com/eap

Username: aig
Password: eap

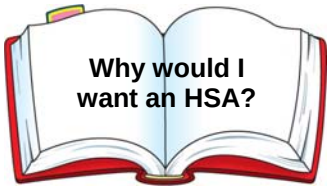


HEALTH SAVINGS ACCOUNT (HSA)

With the Election of the UnitedHealthcare Qualified High Deductible Health Plan (QHDHP) for your insurance coverage, you may also open an HSA.



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



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

What Rules Must I Follow?

- You must be covered under a Q*ualified 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 *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses 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 first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

What Else Do I Need to Know?

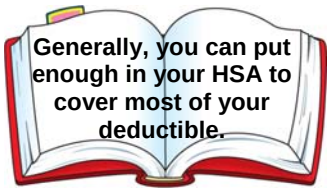
- The contribution limits for 2017 are $3,400 for Single and $6,750 for Family. You cannot put more than this amount in the account in a calendar year; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services. (medical, dental, vision and over-the-counter medically necessary items).

- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- The District is establishing accounts with Optum Bank so you can take advantage of payroll deductions on a pre-tax basis. If you are interested in establishing a Health Savings Account through Optum Bank, please contact the Benefits Department for a consent form.
- Retirees cannot participate in the District's HSA. You will have to set up an account at a bank of your choice.
- Retirees cannot participate in an HSA after age 65.
- **The District will deposit a one time lump sum payment of $520 into the HSA with the first payroll in January and $40 per payroll thereafter for an annual total of $1,440.**
- Per IRS guidelines, the QHDHP minimum in network embedded deductible for 2017 is $2,600 for single.

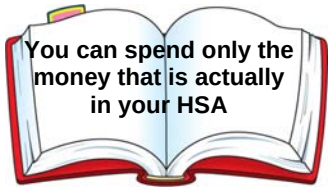
Another advantage is that your account can grow over time.

Since the money always belongs to you, any unused funds carry over from year to year, so you never have to worry about losing your money. That means if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future.

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



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



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

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

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

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

Details about the HSA and more approved items, can be found on the IRS Website at www.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 the ineligible amount.

YOUR HEALTH BENEFITS

Get the Most from Your Benefits

Parkway School District offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

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

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

myHealthcare Cost Estimator

Quickly and easily estimate your health care costs on myuch.com and I n the United Health care Health4Me app with **myHealthcare Cost Estimator**.

Using your benefit information, myHealthcare Cost Estimator….

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

You can use this Information to:

- Plan your care
- Budget for medical expenses
- Find doctors that better meet your needs
- Learn about new treatment options
- Save money

Scan the code to view a demon of **myHealthcare Cost Estimator**

RALLY

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

VIRTUAL VISITS

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

Conditions Commonly Treated Through a Virtual Visit

- Bladder Infection/Urinary Tract Infection
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat
- Stomach Ache

Access to Virtual Visits

Log in to www.myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay for the UnitedHealthcare Base Plan and Premium Plan and the deductible for the QHDHP.

ADVOCATE4ME

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

WELLNESS INCENTIVE

You have until December 31, 2016 to earn your wellness incentive. To qualify for the incentive you need to get your preventive exam, complete the Rally online Health Risk Assessment and complete one other Parkway wellness event or independent wellness-related event. By completing the three wellness initiatives and submitting the required form to the Parkway Benefits Department you will earn $100 (paid out February 2017).

REAL APPEAL

Real Appeal is a weight loss and healthy lifestyle program, available to eligible Parkway School District employees and their dependents as part of our UnitedHealthcare benefit plan. Real Appeal partners with UnitedHealthcare.

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

This program is not available if you are Medicare Eligible.

real appeal

How To Get Started?

Go to parkway.realappeal.com

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

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

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

If you are looking to lose weight or lead a healthier lifestyle, we would encourage you to consider joining the Real Appeal program. If you're ready to enroll, please visit **parkway.realappeal.com**

If you have any questions please contact the Parkway Benefits Department.

CARE OPTIONS AND WHEN TO USE THEM

CONVENIENCE CARE

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

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance. Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center.

We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit our website at www.myuhc.com.

URGENT CARE

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

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

EMERGENCY ROOM

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

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

Convenience Care Center

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Urgent Care

Typical conditions that may be treated at a Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Back Pain or Strains
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Emergency Room

Some examples of emergency conditions may include the following:

- Heavy bleeding Chest pain
- Sudden change in injuries Vision
- Major burns
- Sudden weakness or trouble walking
- Large open wounds
- Spinal
- Difficulty breathing
- Severe head injuries

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

- Serious dysfunction of any of you or your loved one's bodily organ or part

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

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

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

PRIMARY CARE

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

LAB SERVICES

If you require routine lab work consider having these services performed at LabCorp. In most cases, the cost of your lab services will be covered as 100% if coded as preventive. If you choose to use Quest Diagnostics, services associated with the cost of your lab work will apply to the out of network deductible and coinsurance.

IMPORTANT NOTICES

Notice of Material Change (also Material Reduction in Benefits)

Parkway School District has amended the Parkway School District's Benefits Plan. 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 need a copy, please submit your request to your Benefits Department.

Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program call your Human Resources Department and we will work with you to develop another way to qualify for the reward.

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.

Notice of Privacy Practices

Parkway 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 Parkway School District's Benefits Department.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2016. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form in January 2017. 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 the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

You'll need a 1095 form to complete your annual Federal tax return.

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 Parkway School District.

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 1st through January 31st.

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.

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 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 **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)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf

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

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

Medicare Part D Creditable Coverage

(Please read carefully if you or one of your covered dependents is 65 or older)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Parkway School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantra Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Parkway School District has determined that the prescription drug coverage offered by the Parkway Self-Insured Plan (United Health Care – Choice Plus) is on average for all plan participants, is expected to pay out as much as the 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 outside of Parkway?

If you decide to join an outside Medicare drug plan, outside of Parkway, your current Parkway School District coverage may be affected. Your current coverage pays for prescription drugs in addition to other health expenses. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Part D prescription drug coverage in your area. Please refer to your Summary Plan Description for more information about your prescription drug benefit. You can find the summary at www.parkwayschools.net under Programs/Department/Benefits/Open Enrollment 2017.

If you decide to join an outside Medicare drug plan and drop your current Parkway School District coverage, be aware

that you and your dependents will not be able to get this coverage back.

If you are a retired Parkway School District employee or spouse (Medicare eligible and 65 or older), you essentially have four options:

1. Enroll in the Anthem Blue Cross / Blue Shield Medicare Supplement Program through Parkway;
   - You will be accessing Medicare Part D through Express Scripts.
2. Enroll in the Coventry Advantra (formerly GHP) Plan through Parkway.
   - You will be accessing Medicare Part D through Caremark/CVS.
3. Remain on Parkway's UnitedHealthCare Choice Plus Plan (This is a Group Plan and not a Medicare Supplemental Plan);
   - You will be allowed to elect Medicare Part D in the future without a penalty.
   - You must sign up for Medicare Part B with Medicare to optimize your benefits.
4. Drop Parkway Coverage all together and sign up for Medicare Part D.
   - You will not be allowed to re-enroll into any of the Parkway School District sponsored medical plans.
   - You will be allowed to continue dental and vision coverage offered by Parkway School District.

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 coverage with Parkway and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next November to enroll.

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

- Visit **www.medicare.gov** for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at 1-800-772-1213(TTY 1-800-325-0778).

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

Date:	10/15/2016
Name of Entity/Sender:	Parkway School District
Contact - Position/ Office:	Janet Bova Conti Benefits Specialist
Address:	455 N. Woods Mill Road Chesterfield, MO 63017
Phone Number:	(314) 415-8059

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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