2015 Employee Benefits Guide

SCHOOL DISTRICT OF UNIVERSITY CITY

School District of University City

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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.

CONTACT INFORMATION

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COVERAGE	**VENDOR**	**PHONE NUMBER**	**WEBSITE**
MEDICAL	Coventry Health Care of Missouri Policy Number: 622595	(800) 755-3901	www.chcmissouri.com Log into: My Online Services
DENTAL - PPO	Aetna Policy Number: 835816	(877) 238-6200	www.aetna.com
VISION	Vision Benefits of America Policy Number: 1606	(800) 432-4966 For Lasic Savings: (877) 437-6105	www.visionbenefits.com
LIFE / AD&D **VOLUNTARY LIFE** **VOLUNTARY STD**	Reliance Standard Policy Number: 141237	(800) 351-7500	www.reliancestandard.com
EMPLOYEE ASSISTANCE PROGRAM (EAP)	H&H	(314) 845-8302	timh@hhhealthassociates.com
BENEFITS TEAM			
Donna Clifton Eric File	CBIZ	(314) 692-2249 Toll Free (800) 844-4510	dclifton@cbiz.com efile@cbiz.com
Christine Brooks - Benefits Barbara Haddox	School District of University City	(314) 290-4021 (314) 290-4022	cbrooks@ucityschools.org bhaddox@ucityschools.org

Reasons to Call and Who to Call:

Claim Questions—Contact Carrier / CBIZ

I.D. Cards / Numbers—Contact Carrier / CBIZ

Provider Search—Carrier Websites

If Drug Prescription is Denied—Contact Carrier / Doctor

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 service 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.

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

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 – This 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.

Preferred 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.

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.

Understanding Your Plan Options

As an employee of the School District of University City you are offered an employee benefit package that includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), and Voluntary Life / Accidental Death & Dismemberment. The District provides, at no cost to the employee, coverage for Medical under the Base Plan or QHDHP, Dental, Vision and Basic Life / AD&D. You may elect coverage for your eligible dependents for Medical, Dental, and Vision benefits, however you are responsible for the entire cost of your elected dependent coverage.

The District's medical coverage is provided through Coventry Health Plan of Missouri. You are offered the choice of three plan options, our Base Plan, a High Plan, and new this year, a Qualified High Deductible Plan. With the Qualified High Deductible Plan you are allowed to open a Health Savings Account (HSA).

The dental plan is offered through Aetna. This plan is unique as it offers you the option of participating in the PPO or the DHMO. The PPO provides the option of utilizing a network provider where you get the advantage of contracted fees between Aetna and your dentist along with a higher benefit. You may also utilize a non-network provider, however the benefit is slightly lower and you can have higher out-of-pocket expenses. The DHMO can offer a greater benefit, however, it is more restrictive as you must choose a network provider for your dental care. The list of available dentists is limited and you must be on the dentist's eligibility list to receive services. You will receive all dental services from your elected provider and must be referred to a specialist for any special dental procedures. The dental plan does allow you to switch from the PPO to the DHMO at any time, however, when you switch plans, it will be effective the 1st of the following month.

The District offers our vision plan through Vision Benefits of America. The vision plan offers a network of providers where you will receive the best benefit. If you go out of network for services, you will receive a limited reimbursement.

The Basic Life / AD&D benefit is provided by the District through Reliance Standard.

Supplemental Life / AD&D is also provided through Reliance Standard. Coverage is offered for employees and their eligible dependents on a voluntary basis so the entire cost is your responsibility. You may elect up to the guaranteed issue amount within the first 30 days of becoming eligible for benefits. If you elect coverage above the guaranteed issue, or if at a later date, you elect new or additional coverage, evidence of insurability and approval by Reliance Standard is required.

NEW BENEFIT EFFECTIVE OCTOBER 1, 2015…

The School District of University City is offering a Short Term Disability benefit to all full-time employees working 30 hours or more per week. The cost of this benefit will be split 50%/50% between the District and the employee should STD be elected. The benefit covers 66 2/3% of your weekly income up to $1,000. The benefit begins after a 31-day disability period for an accident or sickness and continues until you are no

longer disabled or for a maximum of 4 weeks.

This Benefit Guide provides a brief summary of all the District's benefit plans along with the rates based upon the coverage you select. You will also find notices and other important information in this guide.

ENROLLING IN THE PLANS

ENROLLING IN THE PLANS IS FAST AND EASY - HERE'S HOW:

Enrollment is handled on-line. This means you can review and/or change your benefit information from work, home, the library, or anywhere you can access the internet 24 hours a day, seven days a week. When you access the online enrollment system, your current elections will be displayed. You must make your elections or any necessary changes during the enrollment period. You are encouraged to logon to the CBIZ National Benefit Alliance online enrollment website to check and confirm your current enrollment elections or to make any changes. If your benefits and covered dependents are not correct, you will not be able to change your elections until the next open enrollment.

TO GET STARTED

September 1st to September 14th

- **Go to:** www.myucsdbenefits.com
  Login: Use your Employee ID number
  Password: New Employees:
  Use your Employee ID number
  Returning Employees:
  Use last year's password
- If you do not remember your password, click on the phrase "forgot PIN/Password", on the login screen.

In the event you are not able to get your information then, contact Human Resources to reset your password.

ONCE YOU ARE IN THE SYSTEM

- Read and accept the legal agreement.
- When you start the enrollment process, you are asked to review your demographic information and report any changes.
- You will be directed through several screens that will provide information on all of your benefit plan options. Review your elections and make any necessary corrections
- Update your beneficiary information for the Life and Accidental Death & Dismemberment (AD&D) coverage if necessary.
- Once you have made your elections you need to click on the "Accept Elections" button. You will then be prompted on the next screen to "Submit Elections".
- After you have made your 2015 elections, print a copy for your records.
- If you make an error or want to change your elections after the close of the open enrollment period, you must contact Human Resources.
- If you experience any problems entering your benefit elections, you may contact Donna Clifton at CBIZ Benefits & Insurance Services at 314-692-5812

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; see your Human Resources department for details.

EXAMPLES OF QUALIFYING EVENTS

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- You become eligible for lose
- Medicaid coverage
- You become eligible for Medicare

HOW TO FIND A MEDICAL PROVIDER

To find a participating provider, the network you need to access will be ASO Options PPO Network. This network includes providers in all 50 states. To access a list of providers go to:

www.chcmissouri.com

Locate: Find a Doctor

Enter: Provider Search

Locate Network: PPO ASO Options Network

ELIGIBILITY

WHO CAN YOU ADD TO YOUR PLAN:

If you are a School District of University City new employee, you are eligible for coverage on the first day of the month following your date of hire. You may elect to enroll yourself and your eligible dependents in our medical, dental, vision, and voluntary life benefits. You are automatically enrolled for the District's Basic Life / Accidental Death & Dismemberment.

Eligible:

- **Legal Spouse**
- **Natural and Adopted Children up to age 26**
- **Your Stepchildren**
- **Children placed in your custody for adoption.**
- **Children under your legal guardianship**
- **Children under a qualified medical child support order**
- **Disabled children 26 years of age or older**

Ineligible:

- **Divorced or legally separated spouse**
- **Common law spouse**
- **Same or Opposite Sex Domestic Partners**
- **Foster children**
- **Sisters, brothers, parents, or in-laws, grandchildren, etc.**

MEDICAL INSURANCE

BASE PLAN

Plan Highlights	In-Network	Out-of-Network
Deductible *(per calendar year)* Individual Family	 $750 $1,500	 $1,500 $3,000
Out-of-Pocket Maximum *(per calendar year)* *(includes deductibles & copays)* Individual Family	 $2,500 $5,000	 $4,500 $9,000
Coinsurance *(the amount the plan pays)*	90%	60%
Office Visits (Preventive—100% in-network)	$30 Primary Care Physician $60 Specialist	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	$50 Copay	$50 Copay
Emergency Room	$250 Copay	$250 Copay
Prescription Drug Retail Pharmacy Mail Order Pharmacy	Tier 1 / Tier 2 / Tier 3 / Tier 4 $10 / $50 / $70 / $150 $20 / $100 / $140 / NA	Not Covered

The District contributes the cost of the employee's coverage under this plan. If you elect dependent coverage you will be required to pay the cost of your elected coverage

BASE PLAN EMPLOYEE MONTHLY CONTRIBUTIONS

Below are the employee cost for the Base Plan option. The employee contribution is based upon your annual income.

Base Plan
Annual Salary
Less than $30,000

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$335
Employee & Child(ren)	$225
Employee & Family	$550

Base Plan
Annual Salary
$30,000 to $95,000

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$348
Employee & Child (ren)	$238
Employee & Family	$563

Base Plan
Annual Salary
Over $95,000

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$360
Employee & Child(ren)	$250
Employee & Family	$575

HIGH PLAN

Plan Highlights	In-Network	Out-of-Network
Deductible *(per calendar year)* Individual Family	 $500 $1,000	 $1,000 $2,000
Out-of-Pocket Maximum *(per calendar year)* *(includes deductibles & copays)* Individual Family	 $1,750 $3,500	 $4,000 $8,000
Coinsurance *(the amount the plan pays)*	100%	70%
Office Visits (Preventive—100% in-network)	$25 Primary Care Physician $50 Specialist	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	$50 Co-Pay	Deductible & Coinsurance
Emergency Room	$200 Co-Pay	$200 Co-Pay
Prescription Drug Retail Pharmacy Mail Order Pharmacy	Tier 1 / Tier 2 / Tier 3 / Tier 4 $10 / $40 / $60 / $150 $20 / $80 / $120 / NA	Not Covered

The High Plan is offered as an option for those who want a higher benefit plan. The premium for this plan is higher than the base plan.

HIGH PLAN EMPLOYEE MONTHLY CONTRIBUTIONS

Below are the employee cost for the High Plan option. The employee contribution is based upon your annual income.

High Plan Annual Salary Less than $30,000

Type of Coverage	Employee Monthly Cost
Employee	$10
Employee & Spouse	$515
Employee & Child(ren)	$375
Employee & Family	$880

High Plan Annual Salary $30,000 to $95,000

Type of Coverage	Employee Monthly Cost
Employee	$23
Employee & Spouse	$528
Employee & Child(ren)	$388
Employee & Family	$893

High Plan Annual Salary Over $95,000

Type of Coverage	Employee Monthly Cost
Employee	$35
Employee & Spouse	$540
Employee & Child(ren)	$400
Employee & Family	$905

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

Plan Highlights	In-Network	Out-of-Network
Deductible *(per calendar year)* Individual Family	 $3,000 $6,000	 $6,000 $12,000
Out-of-Pocket Maximum *(per calendar year)* *(includes deductible)* Individual Family	 $3,000 $6,000	 $10,000 $20,000
Coinsurance *(the amount the plan pays)*	100%	60%
Office Visits (Preventive—100% in-network)	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drug Retail Pharmacy Mail Order Pharmacy	Tier 1 / Tier 2 / Tier 3 / Tier 4 Deductible & Coinsurance Deductible & Coinsurance	Not Covered

The Qualified High Deductible Health Plan offers higher deductibles with lower premium. All eligible medical claims are applied to the deductible. Once the deductible is met all in network claims are paid 100%. You are eligible to open a Health Savings Account with this plan.

QHDHP EMPLOYEE MONTHLY CONTRIBUTIONS

QHDHP
All Employees

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$212
Employee & Child(ren)	$137
Employee & Family	$375

If you elect to enroll in the Qualified High Deductible Health Plan you are required to enroll in the Health Savings Account. The District requires $125 per month from the benefit allocation to be deposited in your HSA account.

If you are enrolling in the Health Savings Account for the first time, you **MUST** complete the Coventry HSA enrollment form. This form will be found in the online enrollment process. Your account cannot be set up until this form is signed and returned to Human Resources. Please allow 30 days for Coventry to open your Health Savings Account.

IRS rules dictate calendar maximum deposits into Health Savings Accounts. The maximum amount includes the District's contribution plus any additional deposits you elect to add to your account. You cannot exceed these set maximums.

Maximum allowed deposits for the calendar year 2015 are: **Individual Accounts: $3,350; Family Accounts: $6,650; Employees age 55 and over may contribute an additional $1,000 annually to their HSA.**

HEALTH SAVINGS ACCOUNT (HSA)

Facts about the HSA:

What is 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 banking account.

Why would I want an HSA?

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 Qualified High Deductible Health Plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you 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 eligible for Medicare or Tricare.
- You cannot be claimed as a dependent under someone else's tax return.

What is the difference between Qualified High Deductible Health Plan and a Traditional PPO Plan?

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

What else do I need to know?

- Contributions are based on a calendar year. For 2015, contribution limits are $3,350 for Single and $6,650 for Family coverage. You may not put more than this amount in the account; you may put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per year.
- 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, and vision).
- 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, the money becomes taxable and is subject to a 20% excise tax penalty (like 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. Taxes would, however, still apply.

Another advantage is that your account can grow over time.

Since the money always belongs to you, even if you leave the District, 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 utilize a lot of healthcare services now, your HSA funds will be there if you need them in the future - even after retirement.

The HSA is also an investment opportunity

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.

Generally, you can put enough in your HSA to cover most of your deductible.

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 are age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

You can spend only the money that is actually in your HSA.

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
- Eye exams, eyeglasses, contact lenses, contact solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available 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 a qualified expense. The banking institution is required to report all withdrawals from your HSA. If you use HSA funds for a non-qualified expense, you will be responsible for the taxes on that amount plus a 20% penalty.

When to Use Primary Care, Convenience Care, Urgent Care, Lab Services, or Emergency Care

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

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.chcmissouri.com.

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

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.chcmissouri.com.

URGENT CARE

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

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

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

LAB SERVICES

If you require lab work consider having these services performed at Quest. If you choose to use Quest, services associated with the cost of your lab work will not apply to the deductible and coinsurance and will be covered 100% in most cases.

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

Some examples of emergency conditions may include following:

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

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.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Anthem and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by The FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- **Better alternatives that may cost you less**
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for CSI and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Anthem. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at www.healthcare.gov.

DENTAL INSURANCE

Our dental plan is provided by Aetna. You have the choice between two dental benefit plans. The first option is a Preferred Provider Organization (PPO). The second option is a Dental Health Maintenance Organization (DHMO). If you elect the DMO plan, please note the services are at a fixed rate and you must utilize a DHMO dentist for services. You may choose either plan, however the monthly premium is the same for both plans. You may also move from one plan to the other during the year. To do this, you must make your change before the 10th of the month preceding the month you want the change to take effect. If you change to the DHMO plan, you must have the participating dentist's Aetna ID Number to complete the enrollment.

To find a participating dentist in your elected plan, visit www.aetna.com and locate DocFind®. The list of available dentist is not guaranteed and it is advisable to ask your dentist if they are currently participating or accepting new patients.

Aetna - PPO Benefit Plan

Benefit / Service	In-Network	Out-of-Network
Deductible *(per calendar year)* Individual Family	$50 $150	$50 $150
Preventive Services ♦ Cleanings ♦ Fluoride ♦ Bitewing and Full Mouth X-Rays ♦ Space Maintainers	100% Deductible Waived	100% Deductible Waived
Basic Services ♦ Root Canal ♦ Amalgam (silver) Fillings ♦ Stainless Steel Crowns ♦ Uncomplicated Extractions ♦ General Anesthesia	90% Deductible Applies	80% Deductible Applies
Major Services ♦ Inlays / Onlays ♦ Crowns ♦ Dentures	60% Deductible Applies	50% Deductible Applies
Maximum Per Person Per Year	$1,000	
Orthodontia	50% Deductible Does Not Apply	50% Deductible Does Not Apply
Lifetime Maximum Per Child Prior to Age 20	$1,000	

Certain services may have frequency and/or age limitations. These limits are described in the Aetna certificate of coverage or you can contact Aetna customer service for specific details.

Aetna - DMO Benefit Plan

Code	Procedure	Patient Pays
	Office Visit Co-Pay	$10
D1110	Adult Cleaning	No Charge
D0270	Bitewings	No Charge
D0330	Panoramic X-Ray	No Charge
D2140	Amalgam – 1 Surface	No Charge
D2330	Composite -1 Surface	No Charge
D2752	Crown-Porcelain	$225
D3330	Root Canal—Molar	$175
D4210	Gingivectomy per Quad	$100

Aetna Dental Plan

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$33.91
Employee & Child(ren)	$46.06
Employee & Family	$76.11

VISION INSURANCE

Our Vision benefit is provided by Vision Benefits of America (VBA). The District provides coverage for employees at no cost. You may elect coverage for your spouse and/or children; however, you will be responsible for the premium to cover your dependents. Please notice out-of-network services only provides a reimbursement benefit. You will have to pay for services first then file a claim with VBA.

Vision Benefits of America

Benefits/Service	In-Network	Out-of-Network
Examination Copay	$10 Copay	Up to $35 Allowance
Frequency of Service: Exam Lenses Frames	Every 12 Months Every 12 Months Every 24 Months	
Frame	Receive up to $50 wholesale allowance which is approximately $120 to $150 Retail Allowance	$45 Retail Allowance
Lenses: Single Bifocal Trifocal Lenticular Progressive	 $25 Copay $25 Copay $25 Copay $25 Copay Controlled Cost*	Allowance $30 $40 $60 $80 $60
Contact Lenses: Necessary Elective	UCR** $125 Allowance for services and materials	$250 Allowance $125 Allowance

* Controlled Cost is VBA's allowance. Typical retail cost is $100 to $300. VBA's controlled cost is generally $45 to $130. Retail cost at retail chains (Sears, Target, etc.) is exactly $125.

** UCR refers to Usual Customary and Reasonable charges. To determine the UCR , Vision Benefits of America takes the procedural charge of area providers and calculates an average. Charges above this average become your responsibility.

Vision Benefit of America

Type of Coverage	Employee Monthly Cost
Employee	$0
Employee & Spouse	$2.55
Employee & Family	$4.75

LIFE and ACCIDENTAL DEATH & DISMEMBERMENT

Basic Life and AD&D - All eligible employees receive Basic Life and Accidental Death & Dismemberment coverage. This coverage is provided by the District at no cost to you.

Voluntary Life Insurance - The District offers eligible employees the option to purchase voluntary life insurance for yourself, your spouse, and/or your child(ren).

If you wish to enroll in the voluntary life plan, you may do so during this enrollment period. You may enroll for new coverage or add to your existing coverage. You and/or your family members will be required to complete an Evidence of Insurability form and obtain approval from Reliance Standard before your coverage will take effect. Employees must be enrolled in the plan in order to enroll a spouse and/or eligible children.

Employee Monthly Cost	
Age Band	**Rate per $1,000**
Under 30	$.058
30-34	$.076
35-39	$.10
40-44	$.158
45-49	$.232
50-54	$.43
55-59	$.81
60-64	$1.196
Child	$.18

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to the lesser of $500,000 or 5 times your salary. Guaranteed Issue amount is $150,000 without evidence of insurability.

SPOUSE COVERAGE

Spousal coverage is available in $10,000 increments not to exceed the employee amount up to a maximum of $500,000. Guaranteed issue amount is $50,000 without evidence of insurability.

CHILDREN

Coverage is available for your children up to age 26 whether they are a full-time student or not. You can elect coverage of $2,500, $5,000, $7,500 or $10,000. The amount you select is for each child you cover. The cost is based upon the family unit and not each child. Guarantee issue does not apply to child coverage.

Voluntary Accidental Death & Dismemberment - Voluntary AD&D is available in increments of $10,000 up to $500,000 subject to a limit of 10 times your earnings if you elect over $150,000 of coverage. You may elect single or family coverage.

AMOUNT OF COVERAGE FOR DEPENDENTS IF FAMILY COVERAGE IS ELECTED	
SPOUSE	50% of Employee's Elected Coverage
SPOUSE (WITH DEPENDENT CHILDREN)	40% of Employee's Elected Coverage
EACH DEPENDENT CHILD (WITH SPOUSE)	10% of Employee's Elected Coverage
EACH DEPENDENT CHILD (IF NO SPOUSE)	15% of Employee's Elected Coverage

Employee Monthly Cost	
Rate per $1,000 of Coverage	
Single	$.03
Family	$.04

HOW TO CALCULATE VOLUNTARY PREMIUM

$50,000 Elected Coverage ÷ 1,000 = 50 Units X $0.232 Rate * See Note = $11.60 Monthly Cost

*The premium calculation is based upon the life rate for an employee age 45.

VOLUNTARY SHORT TERM DISABILITY

NEW BENEFIT: Effective October 1, 2015, The School District of University City is offering Short Term Disability coverage to all full-time employees working 30 or more hours per week. This new benefit is offered as income protection in case you become disabled and are unable to work due to an accident or illness.

THE COST: If you elect this benefit you will be responsible for 50% of the monthly premium. The District will contribute the remaining 50%. The monthly premium will be based upon your individual income at the time of your enrollment and could change annually or if your income increases.

BENEFIT: 66 2/3% of your weekly income.

MAXIMUM BENEFIT: $1,000 per week (Note: Amount may be lower based upon your gross weekly salary in effect just before the date of the illness or Disability.)

COVERAGE BEGINS: On the 31st day of sickness or disability (This is the amount of time you must be away from work in order to qualify for the disability benefit.)

MAXIMUM BENEFIT PERIOD: 4 Weeks

RATE: $.11 per $10 of benefit

You must be unable to perform you job or any work for payment, under the care of a physician, and submit a claim for approval by Reliance Standard to receive this benefit.

IMPORTANT BENEFIT INFORMATION

PRE-TAX PREMIUM CONTRIBUTIONS

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This means premiums will be deducted from your gross income. Taxes will then be applied to the remaining payroll amount.

STIPEND IN LIEU OF BENEFITS

The District is again offering a $125 per month stipend to any employee who is eligible for insurance benefits, elects to waive the medical coverage, and can prove they are covered elsewhere.

- The stipend will be paid as taxable income.
- A signed waiver is required along with proof of coverage.

This is an annual election. Your signed waiver and proof of coverage is required every year. The waiver form can be found and printed from the CBAS enrollment site.

Send your completed waiver form along with proof of current coverage to Human Resources. A copy of your current medical identification card is acceptable as proof of current coverage.