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 Contents

Lindbergh Schools

Contact Information

Contacts		
Vendors	**Member Services**	**Website / Email**
Medical: *UnitedHealthcare* Policy Number: 706917	866.844.4864	myuhc.com
Dental: *Delta Dental* Group Number: Base—20711000 High—20721000	800.335.8266	deltadentalmo.com
Vision: *EyeMed* Group Number: 1003644	866.804.0982	eyemed.com
Life / AD&D and Voluntary Life / AD&D: *The Hartford* Group Number: 677878	800.523.2233	thehartford.com
Employee Assistance Program (EAP): *Personal Assistance Services (PAS)*	800.356.0845	paseap.com
Flexible Spending Account (FSA): *CBIZ Flex*	800.815.3023 Fax: 800.584.4185	myplans.cbiz.com
Benefits Team	**Phone**	**Email**
Lindbergh Schools: *Ann Worthen - Benefits*	314.729.2400	annworthen@lindberghschools.ws
CBIZ Benefits & Insurance Services: *Donna Clifton - Sr. Account Manager* *Eric File - Sr. Account Executive*	314.692.2249 314.692.5812 314.692.5848	dclifton@cbiz.com efile@cbiz.com

Reasons to Call	Who to Call
Claims Questions	Carrier / CBIZ
Identification Cards / Numbers	Carrier / CBIZ
Pre-Certification	Carrier
Provider Directories	Carrier Websites
If Drug Prescription is Denied	Provider / Doctor
Payroll Issues / Status Changes / Miscellaneous Issues	Lindbergh Schools

How to use this resource sheet for questions regarding a medical claim:

1. First, contact Member Services,
2. If issue still unresolved, contact Donna Clifton at CBIZ Benefits & Insurance Services, Inc. for assistance.

Understanding Your Plan Options

Employees of Lindbergh Schools who meet eligibility requirements are offered an employee benefit package which includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Supplemental Life / AD&D, Employee Assistance Program, and Retirement Plan options.

The District offers three medical plans administered by UnitedHealthcare. The High PPO Plan and Base PPO Plan options offer higher benefits for a higher premium. The Qualified High Deductible Health Plan (QHDHP), has a higher deductible with lower premiums and gives you the option to contribute to a Health Savings Account (HSA). If you elect the QHDHP, the District contributes $100 per month into your HSA.

The dental plan also offers two options through Delta Dental. Both options are Preferred Provider Organization (PPO) plans which offers you the choice to utilize a PPO network provider, a Premier network provider, or go outside both networks. Utilizing a PPO network provider offers you greater savings through contracted fees and lower out-of-pocket expenses. The Premier network will not balance bill beyond your deductible and co-insurance responsibility as long as expenses are covered under the plan. If you elect to utilize a non-participating dentist, the benefits are paid based on Delta Dental's maximum allowance. You may experience balance billing and higher out-of-pocket expenses.

Vision benefits are offered through EyeMed. The plan also offers a network of providers where you will receive the best benefits. Expenses incurred by utilizing a non-network vision provider will be reimbursed at a limited schedule based upon the services you receive.

Basic Life / AD&D is offered to employees at no cost. You may elect additional Supplemental Life / AD&D for yourself and Supplemental Life for your eligible dependents at a cost based upon the amount you elect and your current age.

The District offers a $1,200 annual stipend to any employee who waives their medical coverage. You must be eligible for the medical insurance benefit and prove you are covered elsewhere. A signed waiver is required and the stipend is paid as taxable income.

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.

WHAT CAN I DO TO KEEP MY MEDICAL COSTS DOWN?

Use Network doctors and facilities

- Check myuhc.com to find network providers near you.
- Ask your provider if they participate in the UnitedHealthcare Choice Plus Network
- Before you have any procedure, be sure to talk to your doctor or the facility to which you are referred to be sure they are in-network.
- If you are balance-billed by an out-of-network provider, contact them and ask if they will lower the charge if you set up a payment plan.

Understand your benefits

- Always review your health plan documents to fully understand your benefits. If you are not sure, contact UnitedHealthcare customer service at the phone number on the back of your ID card.

Get the most out of your insurance by using in-network

Eligibility

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Your legal spouse
- Your or your spouse's child who is under age 26
- Legally adopted child or a child placed for adoption
- Child for which you or your spouse is the legal guardian
- A disabled child who is unmarried and over age 26
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court order.

Ineligible:

- A common law spouse
- Domestic partner
- Divorced or legally separated spouse
- Foster children
- Sisters, brothers, parents, or in-laws, grandchildren, etc.

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
- Death of an insured member
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

HOW ARE NEWBORNS COVERED?

Lindbergh Schools' medical plan covers newborns for up to the first 4 days. Coverage is based upon the Federal law, The Mother's and Newborns' Health Protection Act. This law requires coverage for a 48-hour inpatient hospital stay for natural birth or 96-hour inpatient stay for cesarean section. If coverage beyond the 48 or 96 hours is wanted, the newborn must be enrolled through CBIZ Custom Solutions within the first 30 days. If the medical coverage for a newborn is elected under a spouse's plan, coordination of benefits will take place which will determine if the Lindbergh or a spouse's plan will be the primary payer.

WHAT IF I USE AN OUT-OF-NETWORK PROVIDER?

It is important to ask if your medical provider is a participant of the UnitedHealthcare Choice Plus Network. If your provider is not a participating provider, your claim may be processed based upon what Medicare allows. Non-network claims may be based upon 175% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service. Non-network benefits are then applied to the eligible charges. This means you may be balance-billed for non-eligible charges.

- Go online at myuhc.com. Click on the "Benefits & Coverage" menu, then click on "Coverage Documents".

Ask the provider about their fees before you receive services

- You can ask about fees before you receive services or pharmacy benefits. Contracted fees are not the same for all providers. You have the right to ask before you receive services so you are aware of what your expenses will be. This may not always be possible, however, when it is...ask.
- To estimate and compare costs, you can also go online at myuhc.com and look for "Estimate Health Plan Costs".

Health Care Coverage Options: COBRA and Its Alternatives

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.

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 his 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.

Medical Insurance

UnitedHealthcare - Plan Designs

Features	High PPO Plan		Base PPO Plan		Qualified High Deductible Health Plan (QHDHP) HSA Eligible	
	In Network	Out-of-Network	In Network	Out of Network	In Network	Out-of-Network
Individual Deductible:	$150	$1,000	$500	$1,000	$2,600	$6,000
Family Deductible:	$300	$2,000	$1,000	$2,000	$4,000	$12,000
Co-Insurance:	100%	70%	90%	70%	100%	70%
Out-of-Pocket Maximum: Includes deductible, medical copays, and Rx copays.						
Individual:	$1,000	$4,000	$1,500	$4,000	$2,600	$9,000
Family:	$2,000	$8,000	$3,000	$8,000	$4,000	$18,000
Office Visits - PCP/ Specialist:	$25/$35 Copay	Ded. & Coins.	$30/$40 Copay	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Preventive Care:	100%	Not Covered	100%	Not Covered	100%	Not Covered
Outpatient Lab & X-Ray:	100% after ded	Ded. & Coins.	Ded & Coins	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Urgent Care:	$50 Copay		$50 Copay		Ded. & Coins.	
Emergency Room:	$100 Copay		$200 Copay		Ded. & Coins.	
Prescription Drug Coverage:	$10/$30/$50/ $100 Copay $3,000 Out-of-Pocket Max.	N/A	$10/$40/$60/ $150 Copay $3,000 Out-of-Pocket Max.	N/A	Ded. & Coins.	
90 Day Mail Order Drug Coverage	$25/$75/$125/$250		$25/$100/$150/$375		Available	

Monthly Employee Cost

Type of Coverage	High PPO Plan	Base PPO Plan	Qualified High Deductible Health Plan (QHDHP) HSA Eligible*
Employee	$50.00	$0.00	$0.00
Employee & Spouse	$514.00	$428.00	$314.00
Employee & Child(ren)	$394.00	$316.00	$204.00
Employee & Family	$854.00	$744.00	$518.00

*** If you elect the Qualified High Deductible Health Plan (QHDHP), you may also participate in the Health Savings Account (HSA). The District will deposit $100 on a monthly basis into your HSA. Contact Ann Worthen in the Business Office to obtain the required forms to open your HSA account.**

Health Savings Account (HSA)

A Health Savings Account (HSA) is type of health care plan that involves a tax advantaged savings plan paired with a qualified high deductible health plan. There are two components to a HSA plan: the *qualified high deductible health plan* (required) and the *health savings account* (optional but encouraged).

The *qualified high deductible health plan (QHDHP)* will be designed within the specific regulations established by the IRS. It will consist of the underlying insurance benefits and will include deductibles, co-insurance amounts and costs for various benefits including how prescription drugs are covered. It is important to note that the deductible must be completely satisfied before the plan pays any benefits.

The *health savings account (HSA)* is optional but is recommended that participants fund this account. Individuals who place money in this account will enjoy the following tax advantages:

- Funds that go into the HSA are payroll deducted before taxes are taken so the employee's taxable income is reduced. Generally, you can deposit enough money each year to fund your deductible. Individuals who are age 55 or older are also allowed to contribute extra money into their account.
- Any earnings or investment income in the HSA is not taxed. This bank account can grow tax free.
- Any funds used for qualified health care expenses are not taxed. Additionally, once an individual becomes Medicare eligible, those funds can be used for other items without being taxed.

The HSA is established in your name. It is your bank account and can be taken with you if you change employers. Any money deposited into the account is your money. HSA accounts do not include the "use it or lose it" provision you would see with a flex spending account. Keep in mind that you can only spend money that is actually in your account. If your health care expenses are more than your HSA balance, you will have to pay the remaining cost in another manner such as cash, personal check, credit card, etc. Later, once you have accumulated the funds in your account, you can request reimbursement of what you've spent.

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

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

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

FACTS ABOUT THE HSA

What is a 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 a 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 Q*ualified High Deductible Health Plan (QHDHP)* in order to establish a HSA.
- You cannot establish a HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up a HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare or Tricare (age 65)
- 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 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 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 2017, the **District will contribute $1,200 a year into your account**. The employee contribution levels for 2017 are $2,220 for single coverage and $5,550 for family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year. The employee cannot put more than this amount in the account; but 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 is subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled, or upon account holder's death, the account can be used for other purposes without paying the 20% penalty.
- The savings account can be established with a variety of banking institutions, so you can take advantage of payroll deductions on a pre-tax basis.

This type of health plan may be right for you if…...

- You do not use a lot of medical services.
- You do not have a lot of prescription medications.
- You would like money in a savings account to pay for "Qualified Expenses" permitted under Federal Law. This includes most medical care, dental and vision services.
- You'd like a tax-advantaged savings account.
- You would like more control over your healthcare dollars.
- You would rather pay less in payroll deductions and you can afford the higher deductible.
- Please note: the deductible applies to all services with the exception of wellness.

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

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

Please Note: if you elect to enroll in the QHDHP and you establish a HSA, you will not be eligible to participate in the FSA. You may establish a Limited Purpose FSA, which allows you to set aside pre-tax funds for dental and vision, but not for any expenses covered under the medical plan.

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, 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.

Full Spectrum of Health Care Support

LiveHealth Online

Talk to a doctor anytime—365 days a year from the comfort of your own computer or mobile device.

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed *(as legally permitted in certain states)*.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Private, secure and convenient online visits.

How much does it cost?

The cost for an online doctor visit is just $49 if you don't have a health plan, if your plan doesn't cover online visits or if you haven't met your plan's deductible. If your health plan covers these visits, you may only owe the copay or coinsurance amount. Either way, you will always see what you owe before you begin a visit.

WHEN TO USE LIVEHEALTH ONLINE?

As always, you should call 911 with any emergency; otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

To get started, enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

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
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat

Access to Virtual Visits

Log in to **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, High Plan or the deductible for the QHDHP.

Care Options and When to Use Them

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.

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.

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 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.

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.

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 uhc.com.

LAB SERVICES

If you require lab work please check to be sure the provider you are going to is in-network. Example, Lab Corp is a network provider and Quest is not. Utilizing Quest will cause your benefits to be paid at the non-network level.

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

Some examples of emergency conditions may include the following:

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

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.

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.

PRESCRIPTION DRUG BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by United Healthcare 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 Lindbergh Schools and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Coventry. 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 healthcare.gov. Other important websites to review preventive care information are uhcpreventivecare.com (United Healthcare website) and cdc.gov/vaccines.

Dental Insurance

Delta Dental of Missouri Plan Designs

Features	High Plan			Base Plan		
	PPO	Premier	Out-of-Network	PPO	Premier	Out-of-Network
Individual Deductible:	$25	$25	$25	$50	$50	$50
Family Deductible:	$75	$75	$75	$150	$150	$150
Type I - Preventive Care: (Exams, Cleanings)	100% (No Ded.)	100% (No Ded.)	100% (No Ded.)	100% (No Ded.)	100%	100%
Type II - Basic Procedures: (Fillings, Extractions)	100%	80%	80%	80%	60%	60%
Type III - Major Procedures: (Caps, Crowns)	80%	50%	50%	60%	50%	50%
Endodontics	100%	80%	80%	80%	50%	50%
Periodontics	100%	80%	80%	80%	50%	50%
Type IV—Orthodontia	50% to $1,500 Lifetime Maximum			50% to $1,000 Lifetime Maximum		
Maximum Benefits / Year	$1,500			$1,000		

Monthly Employee Cost

Type of Coverage	High Plan	Base Plan
Employee	$0	$0.00
Employee & Spouse	$40.00	$10.00
Employee & Child(ren)	$45.00	$20.00
Employee & Family	$90.00	$55.00

Vision Insurance

EyeMed Plan Design

Benefits/Service	In-Network	Out-of-Network
Examination Copay	$0	$40 Reimbursement
Frequency of Service: Exam Lenses Frames	 Every 12 Months Every 12 Months Every 24 Months	
Frame	100% up to $130 Retail	$70 Retail
Basic Lenses: Single Bifocal Trifocal Lenticular Standard Progressive	 100% 100% 100% 100% $65 Copay	Reimbursed up to: $30 $50 $70 $70 $50
Contact Lenses: Necessary Cosmetic	 100% $130	Reimbursed up to: $210 $130
Contact Lenses Fit & Follow-Up	Up to $55 Copay	N/A
Laser Vision Discount	Included	Included

- EyeMed uses the INSIGHT Network
- For a complete list of in-network providers near you, use the Enhanced Provider Locator on eyemed.com or call 866.804.0982.
- For Lasik providers, call 877.552.7376

Monthly Employee Cost

Type of Coverage	Base Plan
Employee	$0.00
Employee + 1 Dependent	$6.12
Family	$12.27

Employee Assistance Program (EAP)

Through our EAP contract with our service provider, Personal Assistance Services (PAS), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Marital/relationship concerns
- Parenting challenges
- Financial planning
- Budget/debt problems
- Identity theft
- Job stress
- Legal concerns
- Child care resources and referral
- Education and college planning
- Elder care planning and management
- Emotional health and wellness
- Substance abuse
- Tobacco cessation
- Healthy eating and exercise
- Household management
- Coping with a chronic health condition
- Career planning
- Organization and time management

PAS specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. PAS professionals answer calls 24 hours a day, seven days a week. PAS telephone number is 314-842-6223 or 1-800-356-0845. When you call PAS a representative will answer any questions you have and set up an appointment for you. Please visit the PAS website for additional information at **paseap.com**.

Basic Life and AD&D

Lindbergh Schools offers eligible employees Basic Life and Accidental Death & Dismemberment coverage at no cost to you.

Coverage for your spouse and dependent children is also offered as an option. Coverage in the amount of $2,500 for your spouse and $1,000 for each child is available for $.40 per month.

Voluntary Life and AD&D

You have the opportunity to purchase additional life insurance for yourself and your family members. During your initial enrollment period, you are allowed to elect coverage up to the guarantee issue amount without providing evidence of insurability. In future years, all enrolled employees will be required to provide evidence of insurability in order to increase the voluntary life amount.

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to the lesser of $500,000 or 5 times your salary. Employee coverage includes Accidental Death & Dismemberment in an amount equal to your elected life insurance coverage. Rate includes the AD&D cost.

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $250,000. **Spouse rates are based upon the employee's age.**

Note: New employees are eligible to elect up to $150,000 of coverage for themselves and $50,000 for their spouse without evidence of insurability if enrolled within 30 days of becoming first eligible for the voluntary life benefit.

CHILDREN

Coverage amounts include $1,000, $5,000, or $10,000 for each eligible child in your family. The cost is based upon the family unit and not each child.

UPDATE YOUR BENEFICIARY

Now is a great time to ensure Lindbergh Schools has the most up to date beneficiary information on file. If you wish to change your beneficiary, please update in Custom Solutions and enter your new beneficiary information.

Voluntary Life Rates

Per $1000 of Coverage Per Month Spouse Rates are Based Upon Employee's Age		
Age	Employee	Spouse
Under Age 25	$ .047	$ .063
25 - 29	$ .047	$ .063
30 - 34	$ .056	$ .090
35 -39	$ .074	$ .100
40 - 44	$ .092	$ .152
45 - 49	$ .245	$ .225
50 - 54	$ .420	$ .380
55 - 59	$ .730	$ .690
60 - 64	$ .960	$ .850
65 - 69	$1.580	$1.300
70 - 74	$3.780	$2.000
75+	$3.780	$2.000
Child	$ .090	

HOW TO CALCULATE VOLUNTARY PREMIUM

$50,000 (Elected Coverage) ÷ 1,000 = 50 (Units) X $.245 (Rate * See Note) = $12.25 (Per Month)

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

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 $100 stipend paid on a monthly basis 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 you elect to waive coverage. The waiver form can be found and printed from Custom Solutions.

Send your completed waiver form along with proof of current coverage to Ann Worthen in the Business Office. A copy of your current medical identification card is acceptable as proof of current coverage. If you waive coverage, the monthly stipend will be withheld until the required proof is received.

HSA - BANKING INFORMATION

If you elect to participate in the Qualified High Deductible medical plan you may open a Health Savings Account. This allows Lindbergh Schools to deposit the $100 monthly contribution to your account. The required forms and information on the HSA can be obtained by contacting Ann Worthen at:

annworthen@lindberghschools.ws

SUMMARY OF BENEFIT COVERAGE

The Affordable Care Act requires that a Summary of Benefit Coverage (SBC) for all benefit plans offered by Lindbergh Schools be provided to plan participants so plan differences can be determined. These summaries are available through the Custom Solutions website and also the Lindbergh Schools intranet. They can also be obtained by contacting Ann Worthen in the Business Office at:

annworthen@lindberghschools.ws

Retirement

Are you saving enough? Lindbergh Schools offers the following vehicles which allow you to save for your retirement:

PSRS/PEERS

Public School and Education Employee Retirement Systems of Missouri

As an employee of Lindbergh Schools, if you hold a teaching certificate and work at least 17 hours per week, Lindbergh Schools and you contribute into the Public School Retirement System of Missouri (PSRS) toward your retirement savings. If you do not hold a teaching certificate and work 20 or more hours per week, Lindbergh Schools and you contribute into the Public Education Employee Retirement System of Missouri (PEERS) toward your retirement savings.

Additionally, if you hold a position with Lindbergh Schools as a contracted teacher, you do not contribute toward your Social Security Retirement. However, if you do not hold a position as a contracted teacher with Lindbergh Schools, you, in addition to your contribution into PEERS, contribute toward your Social Security Retirement.

For details regarding your particular situation with PSRS/ PEERS, please sign up to receive your login ID and password to access your membership information at psrs-peers.org. The membership information provided here

includes your account balance to date, your contribution percentage of salary, interest earned to date, and much more.

You may also contact PSRS/PEERS at (573)634-5290 or (800)392-6848 or member_services@psrsmo.org for more information.

CSD Retirement Trust-403(b) and 457(b)

In addition to your PEERS/PSRS retirement, Lindbergh participates in the CSD Retirement Trust bringing you a top of the line 403(b) Salary Reduction plan and a 457(b) Deferred Compensation plan with VALIC as the current investment provider.

The investment line ups in these plans meet or exceed their comparative benchmarks and have some the lowest fees around – rivaling large corporate 401(k) plans. Both of these plans reduce your taxable income now while helping you save for retirement. So a $100 contribution will only reduce your net pay about $75.

In addition to these plans, there is also a 403(b) Roth available. With this plan, contributions go in as taxable. But the earnings growth and subsequent withdrawals at retirement are tax free.

To learn more about these plans, please contact…

Kenneth Klages
VALIC Financial Advisors, Inc.
12312 Olive Blvd, Suite 265
St. Louis, MO 63141
314-346-0047
kenneth.klages@valic.com

We encourage you to understand your choices with regard to your retirement investments.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings.

TYPES OF ACCOUNTS

MEDICAL REIMBURSEMENT ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited. You cannot establish the FSA if you also contribute to a Health Savings Account (HSA).

IRS rules do not allow you to contribute to a health savings account (HSA) if you are covered by any non-qualifying health plan, including a general-purpose health FSA.

DEPENDENT CARE REIMBURSEMENT ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone

you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Maximum Contributions	
Section 125 Medical Account	$2,550
Limited Flexible Spending Account	$2,550
Dependent Care Expense Account	$5,000

You can submit claims through the website at:

myplans.cbiz.com

OR you can submit claims by sending a claim to:

CBIZ Flex
2797 Frontage Road
Roanoke, VA 24017

ACCOUNT STATEMENTS

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto **myplans.cbiz.com** to view account balances, view the expenses that have been paid, and see any other account information.

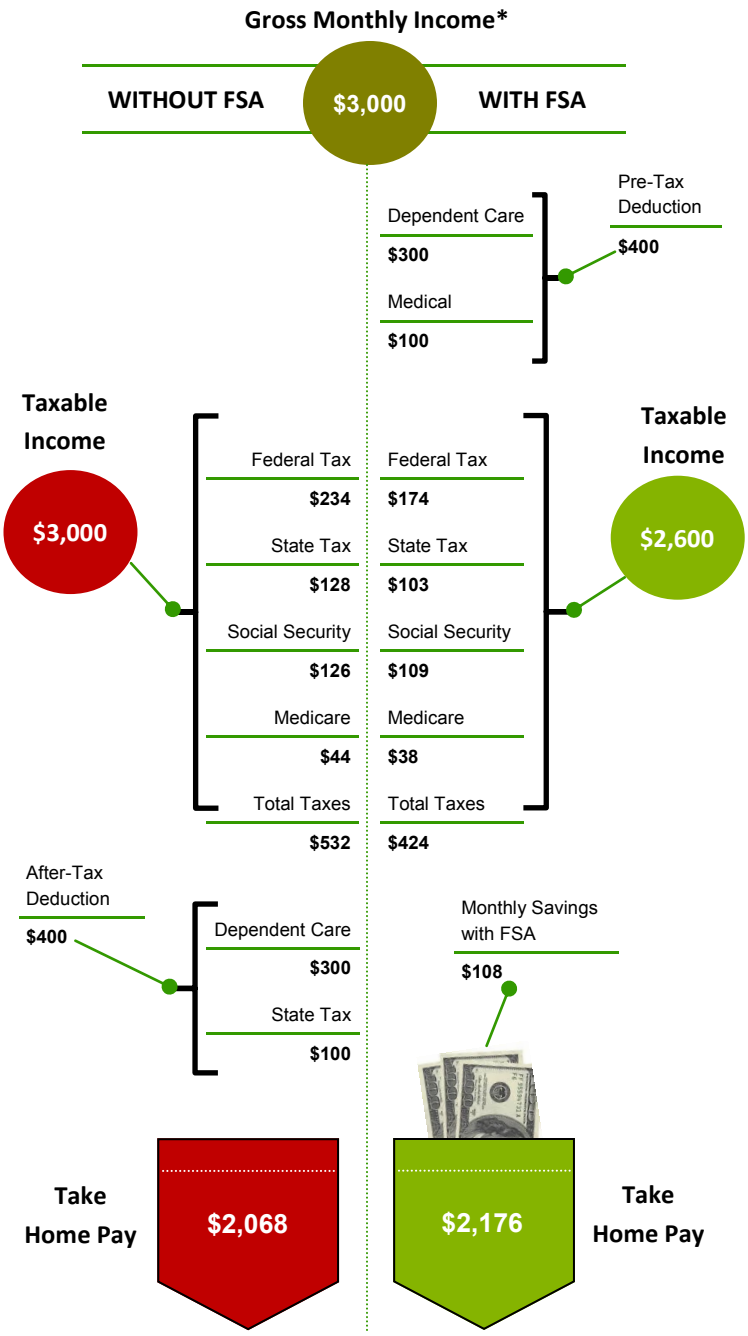
HOW THE ACCOUNT WORKS

When you have eligible expenses not covered under the health insurance plan, such as copayments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. You may also submit a FSA claim form with your receipt and a reimbursement payment will be issued to you directly.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider.

Lindbergh Schools

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

Below is a partial list of eligible expenses that can be reimbursed from a Medical Reimbursement Account. Other out-of-pocket expenses may qualify.

Alcoholism treatment	Laboratory fees
Artificial limbs	Licensed osteopaths
Ambulance	Licensed practical nurses
Braces	Orthodontia
Chiropractors	Orthopedic shoes
Coinsurance and copayments	Obstetrical expenses
Contact lens solution	Oxygen
Contraceptives	Prescription drugs
Crutches	Podiatrists
Deductible amounts	Prescribed vitamin supplements (medically necessary)
Dental expenses	Psychiatric care
Dentures	Psychologist expenses
Dermatologists	Routine physical
Diagnostic expenses	Seeing-eye dog expenses
Eyeglasses, including exam fee	Smoking cessation programs
Handicapped care and support	Sterilization and reversals
Nutrition counseling	Substance abuse treatment
Hearing devices and batteries	Surgical expenses
Hospital bills	

IMPORTANT TO REMEMBER

Employees who enroll in the Qualified High Deductible Plan are required to enroll in a Health Savings Account as $100 per month is contributed by the plan into your account. IRS rules will not allow enrollment in a Flexible Spending Account AND a Health Savings Account at the same time.

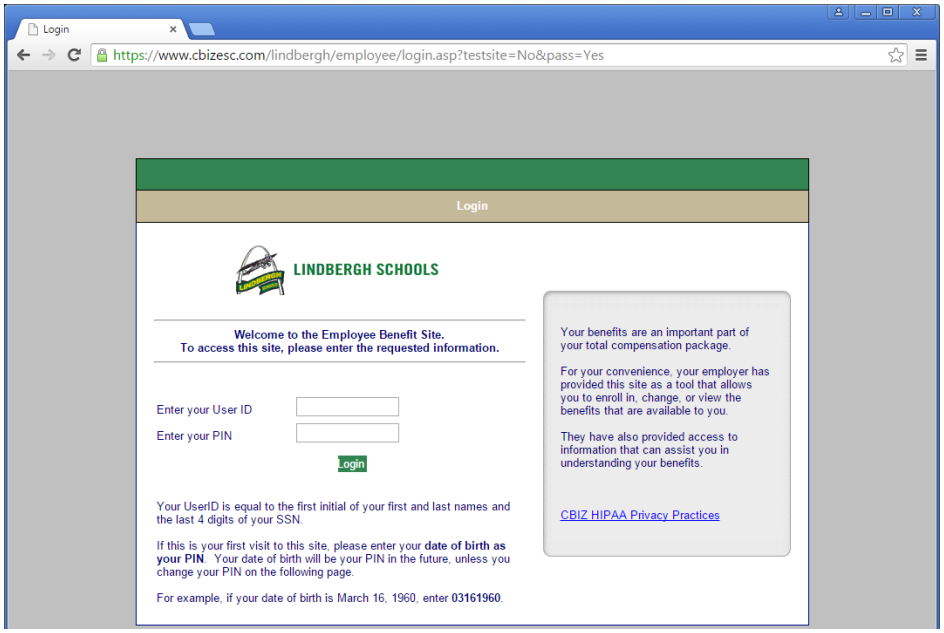
Online Enrollment

ALL EMPLOYEES ARE REQUIRED TO GO ONLINE TO CONFIRM, CHANGE, OR ELECT BENEFITS

Enrollment must be done online at: **cbizesc.com/lindbergh**.

You may use Explorer (Windows), Google Chrome (Windows), FireFox (Windows), and Safari (Mac) to access the site.

- **DO NOT USE A SEARCH ENGINE TO LOCATE THE WEBSITE**
- **IF YOU DO NOT SEE THE PICTURED WEBSITE PAGE, YOU ARE IN THE WRONG PLACE**



Log In Information

USER ID: First Initial of your first name and first initial of your last name and the last four digits of your Social Security Number.

PIN: If this is your first visit to the website, please enter your date of birth as your PIN. Your date of birth will be your PIN in the future, unless you change your PIN. Birth Date format is (MMDDYYYY). Must be an 8 digit number.

- After logging in, look under Elections, then click Enroll/Change Your Benefits. Click Plan Year 2016 and then click on Health and Welfare Benefits Enrollment.
- Your current benefit elections will be reflected during the process.
- At the end of the process you will be asked to submit. If you do not submit your enrollment it will not register in the system. It will be considered incomplete.
- **If your enrollment is complete you will receive a confirmation number**. Print and Save your confirmation number.
- If you need assistance with enrolling, contact Custom Solutions. Phone: 1-877-634-6516
- If you cannot access the system, please contact Donna Clifton at CBIZ. Phone: 314-692-5812

THE ONLINE PROCESS ALLOWS YOU TO:

- Update your beneficiary information for your life insurance
- Confirm or change your coverage on your medical, dental, vision, and voluntary life insurance
- Confirm, add, delete, or change your covered dependents
- Elect your Flexible Spending Account payroll deduction amounts
- Print forms: Waiver Form or Evidence of Insurability Form for Voluntary Life Insurance. Send forms to Ann Worthen at Central Office.
- View Benefit Summaries

Need Assistance? Please contact Ann Worthen at annworthen@lindberghschools.ws

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Ann Worthen at (314) 729-2400 ext. 8640.

Notice of Material Change (also Material Reduction in Benefits)

Lindbergh Schools has amended the Lindbergh Schools' Health 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 the Business Services Department.

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 copays, 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

Lindbergh Schools 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 Lindbergh Schools' Business Services Department.

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 Lindbergh Schools.

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.

More Information

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

Medicaid CHIP Notice

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

If you or your children are eligible for Medicaid or CHIP and you're also 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 **healthcare.gov**.

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

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

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 **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: dol.gov/ebsa/pdf/chipmodelnotice.pdf

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

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

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

Medicare Part D Creditable Coverage

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

Two important things you need to know about your current coverage and Medicare prescription drug coverage:

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

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

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

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

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

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

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

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

Glossary of Terms

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

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

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

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

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 co-payments.

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.