SAINT LOUIS
PUBLIC SCHOOLS

When Life Changes,

You may also need to make changes to your benefits.

2013 St. Louis Public Schools Benefits Reference Guide

Enroll Online

https://portal.adp.com

St. Louis Public Schools Benefits Overview

Welcome to the St. Louis Public Schools annual enrollment period for Calendar Year 2013. Annual enrollment will begin on **Sunday, October 14, 2012** and end at Midnight, CST on **Saturday, October 27, 2012**. You will be able to make corrections from **Sunday, November 4, 2012** through **Saturday, November 10, 2012**, Midnight, CST. Enclosed is your 2013 Enrollment Guide, along with your annual enrollment materials for medical, dental, vision, supplemental life insurance, and flexible spending accounts benefit options.

We encourage you to review the Enrollment Guide and your personal worksheet to determine your selections for 2013. If you do not make an election, a default enrollment will be made for you as described below.

What's New for 2013?

- **Plan designs for 2013 have not changed.**
- Medical Rates for 2013 decreased slightly, thanks in part to our Wellness Program participation and efforts from our employees.
- Dental Rates for 2013 have increased. Please keep in mind that dental rates had not increased for four years.
- Walgreen's is now part of the Express Scripts Network; employees can utilize Walgreen's for prescription needs.
- Many women's contraceptives are now covered at 100% with no co-pay due; please call the member services at Express Scripts for additional information.
- All employees are required to have Beneficiary Designations in place for their Life Insurance coverage.

What you need to do

- Read the enclosed materials carefully to get answers to your questions.
- Discuss your options with your family. Make sure that you include any individuals who will be affected by your elections in the decision making process.
- **Enroll by the deadline, which is Midnight, CST October 27, 2012**. If you decide to change plans or delete/add eligible dependents, refer to the instructions in the Enrollment Guide. All eligible employees should enroll online at https://portal.adp.com. If you have questions or do not have access to a computer, call the Benefits Call Center at 1-866-345-SLPS (7577). Customer Care Representatives will be available to help you throughout the enrollment period and on an ongoing basis after the enrollment deadline.
- Finally, you will receive a personalized confirmation statement around the week of October 29th. If your confirmation does not reflect your elections for 2013, call the Benefits Call Center. You will not be allowed to make corrections after November 10, 2012, Midnight, CST.

What you need to remember

- Deductions for dependent coverage are taken from 24 paychecks for 12-month employees and 20 paychecks for non-12-month employees.
- Be sure to review your first paycheck in January 2013, to ensure that the correct amount has been deducted.
- **If you are participating in Flexible Spending Accounts, you must indicate the amount annually.**
- You may select any combination of medical, dental, and/or vision plans, as well as any combination of coverage categories. The choice is up to you!

Do not forget to make your benefit choices no later than Midnight, CST Saturday, October 27, 2012.

If you do not enroll

If you do not enroll by **October 27, 2012**, you will not be able to make changes to your benefits until the correction period or next open enrollment period - unless you have a change in status or experience another qualified event under which election changes are allowed. You will default to the coverages listed below.

Default Coverage for 2013

BENEFIT	COVERAGE LEVEL	PLAN
Medical and Prescription Drug Plan	Same as in 2012	Same as 2012
Dental Plan	Same as in 2012	Same as 2012
Vision Plan	Same as in 2012	Same as 2012
Basic Life Insurance	Same as in 2012	Same as 2012
Supplemental Life Insurance	Same as in 2012	Same as 2012
Healthcare Reimbursement Account	No Coverage	No Coverage
Dependent Care Reimbursement Account	No Coverage	No Coverage

Keep this guide for future reference.

St. Louis Public Schools

Important Dates to Remember

Your Open Enrollment Dates Are:
October 14, 2012 through October 27, 2012

Your Correction Dates are:
November 4, 2012 through November 10, 2012

Your period of coverage dates are:
January 1, 2013 through December 31, 2013

Welcome

The Board of Education of the City of St. Louis is committed to providing employees an affordable, high-quality employee benefits program while managing healthcare and vendor costs effectively.

It's time to enroll for your 2013 health and welfare benefits. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Annual enrollment is the one time during the year when you can make changes to your benefits (other than when you have a qualified family status change such as marriage, death, birth or adoption of a child, etc.). Don't miss this opportunity to review your benefit needs and the needs of your family. Review your current coverage; think about whether your needs have changed since you made those benefit decisions.

- Open enrollment will take place from Sunday, October 14 through Saturday, October 27, 2012 at Midnight, CST.
- Review this guide and your personal enrollment worksheet before you enroll for your benefits. If you have any questions, you may contact the Benefits Call Center phone line at 1-866-345-SLPS (7577) for more information.
- If you are enrolling online - the enrollment website will be available **24 hours a day throughout the enrollment period. To enroll, visit the enrollment website at https://portal.adp.com. New users will need the registration pass code: SLPS-ESS.**
- You can make changes online or call the Benefits Call Center at 1-866-345-SLPS (7577).

Table of Contents

Your 2013 Enrollment Materials

Your enrollment packet provides you with general and personalized information to help you make your 2013 elections, along with information on how to enroll online.

Your Packet Contains:

This enrollment guide - Provides an overview of your benefits for 2013, including details on each enrollment decision, information on how to enroll and where to find more information about your benefit options.

Your personal enrollment worksheet - Presents personalized benefits information such as your benefit options and associated premium costs.

Key Dates for Open Enrollment

You can make changes for benefits during the Open Enrollment period - October 14, 2012 through October 27, 2012, CST. If you don't enroll during this period, you will receive default benefits. (See "If You Do Not Enroll" on page 2 for more information.) You will be able to make changes or corrections from November 4, 2012 through November 10, 2012 at Midnight, CST.

The chart below provides more details about the coming weeks.

EVENT	TIMING	WHAT TO EXPECT
Open Enrollment	October 14 - October 27 at Midnight, CST	• Enrollment for Medical, Dental and Vision benefits for you and your dependents. • Enrollment for Supplemental Term Life Insurance for you and your dependent(s). • Election to participate in the Flexible Spending Accounts. • **Beneficiary Designation Online.**
Confirmation statements arrive at your home	Week of October 29, 2012	• If your confirmation does not reflect your elections for 2013, call the Benefits Call Center phone line at 1-866-345-SLPS (7577).
Corrections	November 4 through November 10, 2012 at Midnight, CST	• Call before November 10, 2012, Midnight CST to correct any errors or discrepancies with your confirmation statement.
New benefit elections effective	January 1, 2013	• Your new benefits become effective.

How to Enroll

Prepare

Step 1: Read the Employee Benefits Enrollment Guide to learn about important changes to the benefits program for the new Plan Year. Review the benefits plan design and the costs for each benefit plan and consider changes that you want to make during Open Enrollment.

Step 2: Examine your personalized worksheet for current elections. Mark your choice for each plan on your worksheet.

Step 3: Have personal and dependent information available, such as Social Security numbers, birthdates, and bi-weekly amount that you want to contribute to a Flexible Spending Account (FSA) if you are participating.

Access Website

Step 1: Log onto https://portal.adp.com (new users refer to annual enrollment notification for instructions) and select the link "Enroll in 2013 Benefits."

Step 2: Click Continue to find instructions on each screen to guide you through the enrollment process.

Step 3: Complete the security screen before you enter your enrollment selections. You will need your Social Security number and your Personal Identification Number (PIN).

Enroll

Step 1: With your worksheet in hand, choose from the available options on each screen to obtain or complete benefits information.

Step 2: Review Personal Information and Current Dependents sections and update appropriately. Keep in mind that adding dependent information does not automatically enroll your dependents in any coverage. You must still select the plan option and coverage level to enroll your dependents.

Step 3: Continue to follow the instructions and steps to enter your choices for your 2013 benefits.

Confirm

Step 1: When you are finished, click on the Submit button to save your selections.

Step 2: Write down your confirmation number. You have the opportunity to receive an e-mail confirmation - just enter your e-mail address when prompted during the enrollment process.

Step 3: You may also print the Confirmation page to keep a copy for your records.

Step 4: During the week of October 29, 2012, you will receive a statement confirming your final benefits selections for 2013. To make corrections to your selections, simply go back to the website (https://portal.adp.com) as many times as you want beginning November 4 through November 10, 2012, Midnight, CST.

Step 5: If your confirmation does not reflect your elections for 2013, call the Benefits Call Center, 1-866-345-SLPS (7577), Monday through Friday, 7:00 a.m. to 7:00 p.m. CST.

Step 6: To log off, press Continue at the bottom of the page.

Eligibility

Who is Eligible

You can participate in the SLPS Benefits Plan if you are an eligible employee. The district defines an eligible employee as a full-time permanent employee with a scheduled work week of 30 hours or more. Eligible dependents can participate in some of the benefit plans.

Your eligible dependents may include your:

- Legal spouse (unless legally separated);
- Dependent child until the end of the month in which he or she reaches age 26 (please see definition below);
- The term Child includes any of the following:
  - A natural child.
  - A stepchild.
  - A legally adopted child.
  - A child placed for adoption.
  - A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- To be eligible for coverage under the Policy, a Dependent must reside within the United States.
- The definition of Dependent is subject to the following conditions and limitations:
  - A Dependent includes any child listed above under 26 years of age.
  - A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

If you opt out of medical coverage for yourself or waive coverage for your dependents, you cannot enroll until the next annual enrollment period unless you have a qualified life event or change in status, as described below.

When Coverage Begins

For newly hired or newly eligible employees, coverage is effective the 1st of the month following your hire date or eligibility date.

When You Can Make Changes

In general, you can make changes to your benefits coverage during annual open enrollment. However, you can make changes during the year if you have a qualified life event or change in status. Any changes you make for yourself and your dependents must be consistent with and on account of your change in status. For example, you can enroll your newborn in medical coverage, but you cannot drop coverage for your spouse or change medical options because of the birth of your child.

Qualified life events and changes in status that permit coverage changes are:

- Employee gains a tax dependent, i.e., through birth, legal adoption or placement of a child for adoption
- Marriage
- Divorce, annulment or legal separation
- Dependent who reaches age 26 or no longer meets eligibility requirements
- Spouse gains or loses coverage due to gaining or losing employment/ eligibility with current employer
- Death of a spouse
- Death of a dependent child
- Spouse/dependent becomes Medicare/Medicaid eligible or ineligible
- Dependent loses coverage

Coverage Levels

If you choose to enroll in the Medical and/or Dental Plans, you can elect coverage for:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

For the Vision Plan, you can elect coverage for:

- Employee Only
- Employee + 1 Dependent
- Employee + 2 or More Dependents

For the Supplemental Life Insurance Plan, you can elect coverage for:

- Employee Only
- Spouse
- Children

For the Flexible Spending Accounts, you can elect either or both:

- Healthcare Reimbursement Account
- Dependent Care Reimbursement Account

Cost of Coverage

The District pays the cost for your coverage (employee only) in the Base Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children and the difference in cost between Base and Buy-up plans on a pre-tax basis.

The District pays the cost of your coverage (employee only) for Basic Term Life Insurance which includes coverage for AD&D. You pay the cost for your Supplemental Life Insurance on an after-tax basis.

You pay the cost for the Flexible Spending Accounts on a pre-tax basis. See your personal enrollment worksheet for specific cost information.

Change in Status

Listing of Allowable/Non-allowable Changes

The Change in Status charts on the following pages list the changes that you may make to your current benefits if you have a qualified change in status event. ***Note:*** *The plan options for Medical cannot change from one plan to the other, regardless of CIS event.*

If you have a qualified life event, you must make your benefit changes within 30 days of the actual event using the Benefit website, **https://portal.adp.com**. You may also contact the Benefits Call Center at 1-866-345-SLPS (7577), from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

Otherwise you cannot make changes until the next benefits enrollment period. Most coverage changes due to a qualified life event or change in status are effective on the event date, if submitted within 30 days of the event. Please refer to the next few pages for a list of allowable changes based on your qualifying event.

Birth or Adoption *(If your newborn has not been assigned a SSN, then please enter your SSN)*		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Children	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	Enroll Increase Coverage	Drop Coverage Decrease Coverage
Spouse/Dependent Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Drop Spouse Drop Children	Enroll or Drop Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Change in Status

Marriage		
	Allowed	**Not Allowed**
Medical	Enroll or Drop Self Add Spouse Add or Drop Children	Drop Spouse
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended with exception of $20,000 guarantee with no pend	
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Divorce/Annulment/Legal Separation		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add or Drop Children	Drop Self Add Spouse
Dental and Vision	Drop Spouse Add or Drop Children	Add Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A

Change in Status

Spouse/Dependent Gain Employment		
	Allowed	**Not Allowed**
Medical	Drop Self Drop Spouse Drop Child	Enroll Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Limitations	N/A
Spouse/Dependent Loses Employment		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Child	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Enroll Self Increase Coverage	Drop Coverage Decrease Coverage
Dependent Care FSA	No Limitations	N/A

Change in Status

Death of Spouse		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add Children	Drop Self Add Spouse Drop Children
Dental and Vision	Drop Spouse Add Children	Add Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Death of Dependent		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	Drop Coverage Decrease Coverage	Enroll Increase Coverage

Change in Status

Dependent Loss of Coverage (turns age 26)		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Coverage and Cost changes to Dependent Care FSA		
	Allowed	**Not Allowed**
Medical	No Changes Allowed	N/A
Dental and Vision	No Changes Allowed	N/A
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	No Changes Allowed	N/A
FSA - Dependent Care	Drop Coverage Increase Coverage Decrease Coverage	N/A
Spouse/Dependent no longer Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Add Spouse Add Children	Enroll or Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	Add Coverage Increase Coverage	Drop Coverage Decrease Coverage
FSA - Dependent Care	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Medical Plans

Your health care options for 2013 will include a choice of the following:

- UnitedHealthcare Choice Plus Base
- UnitedHealthcare Choice Plus Buy-up
- Opt out of medical coverage

UnitedHealthcare insures and administers both medical plans.

If you choose to opt out of Medical coverage because you have coverage under another plan, you will receive a monthly credit. A credit of $50 per month will be paid to 12-month employees; non-12-month employees receive a $60 monthly credit. This amount will be included in the last paycheck of each month, as taxable wages.

Comparing Your Medical Plan Options

Although both UnitedHealthcare Choice Plus Base and UnitedHealthcare Choice Plus Buy-up are known as Point of Service (POS) plans, there are some differences between the plans.

UnitedHealthcare Choice Plus Base

This plan offers in- and out-of-network benefits, and you do not need to choose a primary care physician (PCP) or obtain a referral to see a network specialist. Your cost for care is lower when you use network providers. You can receive care from providers outside of the network, but your share of the cost is higher and you are responsible for paying any expenses that exceed the "Eligible Expense." (The "Eligible Expense" is a percentage of the published rates allowed by Medicare for the same or similar services.)

You pay a set fee, or co-payment, for in-network physician office visits under this plan. When you use network providers, you often pay only a co-payment for covered services. Network services have lower deductibles and out-of-pocket costs. However, the co-payments and deductibles are higher for in-network benefits under this plan as compared to the UnitedHealthcare Choice Plus Buy-up plan.

After you meet the annual deductible, the plan shares a percentage of covered medical expenses up to the "Eligible Expense" limits. Your share of the expenses is the coinsurance. For hospital stays, surgeries, extensive tests, lab tests and X-rays, you pay your annual deductible, the coinsurance and any separate hospital co-payments or confinement deductibles, if applicable. Once you reach the annual out-of-pocket maximum, the POS pays for certain covered expenses at 100% of "Eligible Expense" limits. Network care expenses are based on the contracted fees with that network provider.

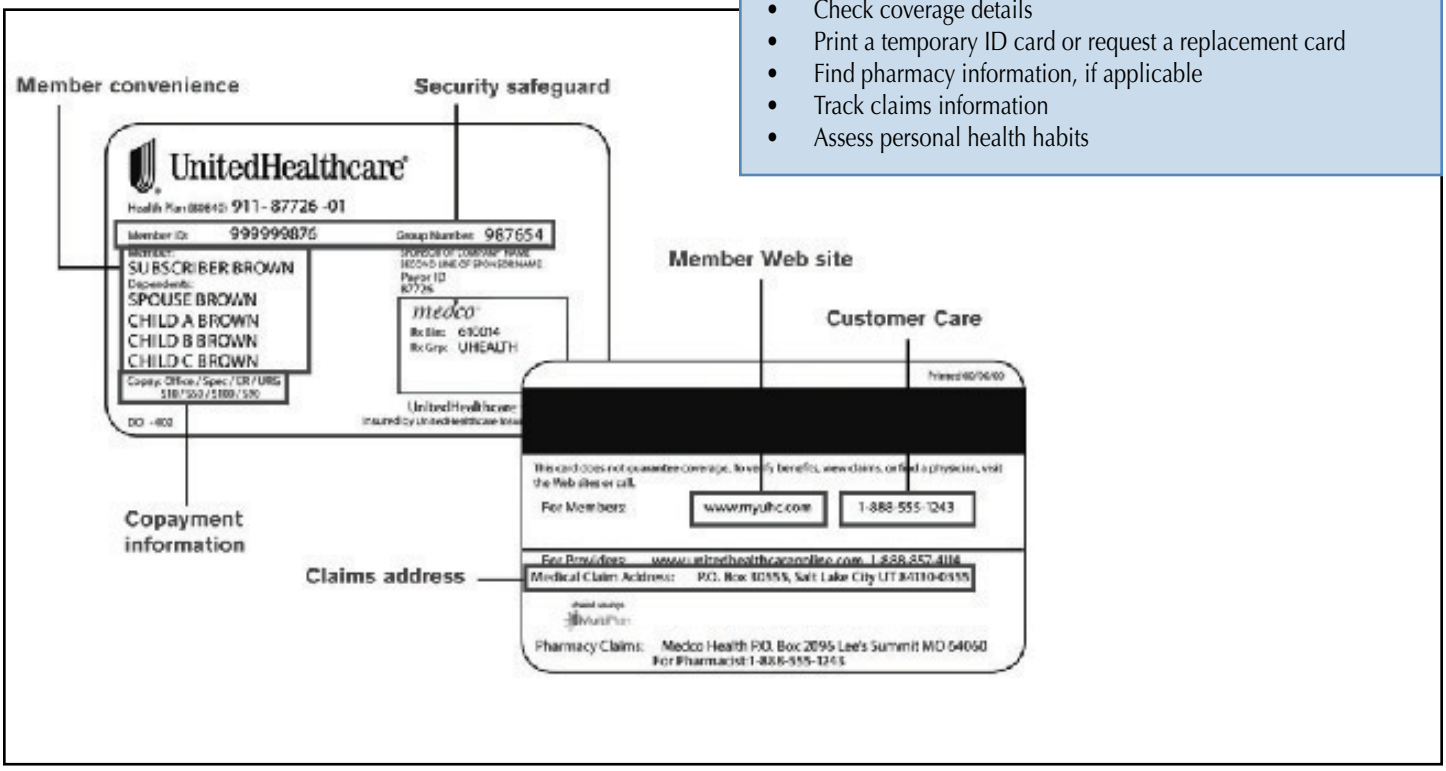
UnitedHealthcare Choice Plus Buy-up

This plan works similar to the UnitedHealthcare Choice Plus Base plan. Under the UnitedHealthcare Choice Plus Buy-up plan, the co-payments and deductibles for in-network benefits are less.

Member website

With access to the Internet, members can access personalized health information at **myuhc.com**:

- Find and compare doctors and hospitals in our network
- Check coverage details
- Print a temporary ID card or request a replacement card
- Find pharmacy information, if applicable
- Track claims information
- Assess personal health habits



Plan Comparisons

The following chart compares your benefits under the Choice Plus Base and Choice Plus Buy-up plan options.

Medical Plan				
	Choice Plus Base		Choice Plus Buy-up	
Deductible	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Individual	$500	$1,000	$200	$400
Family	$1,000	$2,000	$400	$800
Coinsurance (excludes deductible)	80%	70%	90%	70%
Individual Out-of-Pocket Max	$2,500	$5,000	$1,000	$2,000
Family Out-of-Pocket Max	$5,000	$10,000	$2,000	$4,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Physician Office Visit				
Illness/Injury	$25/$35 Copay	70% AD	$15/$30 Copay	70% AD
Preventative Care	100%	70% AD	100%	70% AD
Hospital Services				
In-Patient	80% AD	70% AD	90% AD	70% AD
Out-Patient	80% AD	70% AD	90% AD	70% AD
Emergency Care				
Hospital Emergency Room	$250 Copay	$250 Copay	$150 Copay	$150 Copay
Urgent Care	$75 Copay	70% AD	$50 Copay	70% AD
Other Services				
Outpatient X-rays & Lab (except CT Scans, PET Scans, MRIs, and nuclear medicine)	100%	70% AD	100%	70% AD
Chiropractic Services	50% no deductible	50% no deductible	50% no deductible	50% no deductible
Physical Therapy	$25 Copay	70% AD	$15 Copay	70% AD
Durable Medical Equipment	80% AD	70% AD	90% AD	70% AD

VISION BENEFIT –

under your UnitedHealthcare Choice Plus Base and Choice Plus Buy-up plans

- Routine vision exam every other calendar year (including refraction) at your office visit co-pay.
- Preferred pricing on eyeglasses and contact lenses.
- Services must be performed at a Routine Vision network provider, which consists of private practice and retail optical providers.

How to Receive Plan Benefits

Each time you need medical care, you decide the level of benefits by choosing in- or out-of-network providers. If you want in-network benefits, be sure to confirm that your provider is part of the United HealthCare network before you receive care. If your provider is not part of the network, ask if he or she would be willing to join.

To choose a network provider, go to the UnitedHealthcare website and click on *Find Physician, Lab, or Facility*. Then, follow the instructions on the UnitedHealthcare website.

When you use an in-network provider, you do not have to file a claim - your provider files a claim directly with UnitedHealthcare. Depending on the type of service you receive, you will pay a co-payment amount or coinsurance and the plan pays the remaining covered amount. When you use an out-of-network provider, you pay the full cost to the provider and file a claim to be reimbursed a percentage of the covered expenses for medically necessary services, after you meet your annual deductible.

UnitedHealthcare Choice Plus Base

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

- You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.
- Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.
- Emergencies are covered anywhere in the world.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.
- Vision and hearing screenings are covered.

Choice Plus Benefits Summary

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $500 per Covered Person per calendar year, not to exceed $1,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $2,500 per Covered Person, per calendar year, not to exceed $5,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit.	**Annual Deductible:** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $5,000 per Covered Person, per calendar year, not to exceed $10,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit.
1. Ambulance Services -Emergency only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses	Same as Network Benefit
2. Dental Services -Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year.	20% of Eligible Expenses	*30% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$250 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	$25 per visit	30% of Eligible Expenses
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	20% of Eligible Expenses	*30% of Eligible Expenses

UnitedHealthcare Choice Plus Base

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	20% of Eligible Expenses	*30% of Eligible Expenses
8. Hospital -Inpatient Stay	20% of Eligible Expenses	*30% of Eligible Expenses
9. Injections Received in a Physician's Office	$25 per visit.	30% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	20% of Eligible Expenses	30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	30% of Eligible Expenses 30% of Eligible Expenses 30% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services -CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	30% of Eligible Expenses
Outpatient Therapeutic Treatment	20% of Eligible Expenses	30% of Eligible Expenses
12. Physician's Office Services	Preventive medical care: No Copayment Sickness & Injury: $25 per visit, except that the Copayment for a Specialist Physician Office visit is $35 per visit. No Copayment for immunizations for children from birth to age five.	30% of Eligible Expenses 30% of Eligible Expenses No Copayment for immunizations for children from birth to age five.
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year. This limit does not apply to breast prostheses.	20% of Eligible Expenses	30% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	$25 per visit	30% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	20% of Eligible Expenses	*30% of Eligible Expenses
18. Transplantation Services	*20% of Eligible Expenses	*30% of Eligible Expenses Benefits are limited to $30,000 per transplant. Please note that this limitation does not apply to dose-intensive chemotherapy or bone marrow transplants.
19. Urgent Care Center Services	$75 per visit	30% of Eligible Expenses

UnitedHealthcare Choice Plus Base

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
Additional Benefits		
Chemical Dependency Services Must receive prior authorization through the Mental Health/Substance Abuse Designee.	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Dental Anesthesia and Facility Charges	*Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Hearing Screenings for Newborns	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Mental Health Services Must receive prior authorization through the Mental Health/Substance Abuse Designee for Benefits. (This requirement is waived for the first two outpatient sessions.)	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Osteoporosis Treatment	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
PKU Formula	20% of Eligible Expenses	30% of Eligible Expenses
Spinal Treatment Copayments or coinsurance for Covered Health Services provided within the scope of a Chiropractor's license will not exceed 50% of the total cost of any single chiropractic service as defined by Missouri state law.	50% Deductible does not apply	50% Deductible does not apply

Exclusions

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings *Dental Services - Accident only* and *Dental - Anesthesia and Facility Charges*. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (not including hospitalizations and anesthesia for Covered Persons who meet the requirements) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Covered Persons with conditions outlined in (Section 1: What's Covered-Benefits) under *Dental-Anesthesia and Facility Charges*. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self- injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. This exclusion does not apply to the treatment of phenylketonuria or any inherited disease of amino or organic acids.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure.
(Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service -see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;

(2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends. This exclusion does not apply if you are eligible for and choose Continuation of Coverage. For more information, see Section 8 of the COC under the heading *Qualifying Events for Continuation of Coverage under State Law*.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

UnitedHealthcare®

Choice Plus Base Plan 101

Coverage Period: 1/1/2013 – 12/31/2013

Summary of Coverage: What This Plan Covers & What it Costs **Coverage for: Employee/Family** **Plan Type: PS1**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling the Member Service number listed on the back of your ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual / **$1,000** Family Non-Network: **$1,000** Individual / **$2,000** Family. Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge"	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No, there are no other deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Network: **$2,500** Individual / **$5,000** Family Non-Net:work: **$5,000** Individual / **$10,000** Family. Other limits apply – see the chart that starts on page 2	The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services, prescription drugs and copays.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see **www.myuhc.com** or call the Member Service number listed on the back of your ID card for a list of network providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-741-8786 for Member Services or 1-866-336-9369 for Employer/Broker Services or visit us at www.myuhc.com. 1 of 7
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call the telephone numbers above to request a copy.

- **Co-payments** (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** (co-ins) is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an Network Provider	Your cost if you use an Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$35 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	50% co-ins for Manipulative (chiropractic) services*	50% co-ins for Manipulative (chiropractic) services*	*Deductible does not apply
	Preventive care / screening / immunization	No Charge	30% co-ins	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins	----------None----------
	Imaging (CT / PET scans, MRIs)	20% co-ins	30% co-ins	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay. Mail-Order: $20 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply. Tier 1 Contraceptives covered at No Charge. Plasma/blood products, focalin, depigmentation agents, photo aged skin, injectable cosmetics, hair growth, and PKU are not covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $25 copay. Mail-Order: $50 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $40 copay. Mail-Order: $80 copay	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	20% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Physician / surgeon fees	20% co-ins	30% co-ins	----------None----------
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	----------None----------
	Emergency medical transportation	20% co-ins	20% co-ins	----------None----------
	Urgent care	$75 copay per visit	30% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	20% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Physician / surgeon fees	20% co-ins	30% co-ins	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$25 copay per visit	30% co-ins	----------None----------
	Mental / Behavioral health inpatient services	20% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Substance use disorder outpatient services	$25 copay per visit	30% co-ins	----------None----------
	Substance use disorder inpatient services	20% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
If you are pregnant	Prenatal and postnatal care	$25 copay	30% co-ins	Additional copays, deductibles, and co-ins may apply. Routine pre-natal care is covered at No Charge, after first visit.
	Delivery and all inpatient services	20% co-ins	30% co-ins	Additional copays, deductibles, co-ins and Inpatient Notification may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins	30% co-ins	Limited to 60 days per policy period. Pre-Notification required for Non-Network benefits.
	Rehabilitation services	$25 copay per outpatient visit	30% co-ins	Depending on the type of therapy, there is a limit of 20-36 visits per policy period.

Common Medical Event	Services You May Need	Your cost if you use an Network Provider	Your cost if you use an Non-network Provider	Limitations & Exceptions
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation Services.
	Skilled nursing care	20% co-ins	30% co-ins	Limited to 60 days per policy period, limit is combined with IP Rehabilitation Services. Pre-Notification required for Non-Network benefits.
	Durable medical equipment	20% co-ins	30% co-ins	$2,500 maximum per policy period if the benefit/device is determined to be non-essential. Pre-Notification required for DME over $1,000 or no coverage.
	Hospice service	20% co-ins	30% co-ins	Limited to 360 days during the entire period of time on the policy. Pre-Notification required for Non-Network benefits
If your child needs dental or eye care	Eye exam	$25 copay per visit	30% co-ins	1 exam every 2 years
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult/Child)	• Glasses • Habilitative Treatment • Infertility Treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Routine eye care (Adult) – may be covered with limitations	• Hearing aids – may be covered with limitations	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323x1565 or visit http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to *appeal* or file a *grievance*. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com or California Department of Insurance at 1-800-927-4357 or visit http://www.insurance.mo.gov

Additionally, a consumer assistance program may help you file your appeal. Contact Missouri Department of Insurance, Consumer Affairs Division at 1-800-726-7390. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

- Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
- 若需要中文协助，请拨打您会员卡上的电话号码
- Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
- Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan pays** $6,130
- ☐ **You pay** $1,410

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$500
Co-pays	$40
Co-insurance	$800
Limits or exclusions	$150
Total	**$1410**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan pays** $4,240
- ☐ **You pay** $1,160

Sample care costs:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$170
Co-pays	$910
Co-insurance	$0
Limits or exclusions	$80
Total	**$1160**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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UnitedHealthcare Choice Plus Buy-up

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

- You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.
- Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.
- Emergencies are covered anywhere in the world.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.
- Vision and hearing screenings are covered.

Choice Plus Benefits Summary

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $1,000 per Covered Person, per calendar year, not to exceed $2,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit.	**Annual Deductible:** $400 per Covered Person per calendar year, not to exceed $800 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $2,000 per Covered Person, per calendar year, not to exceed $4,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit.
1. Ambulance Services -Emergency only	Ground Transportation: 10% of Eligible Expenses Air Transportation: 10% of Eligible Expenses	Same as Network Benefit
2. Dental Services -Accident only	*10% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$150 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	$15 per visit	30% of Eligible Expenses
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses

UnitedHealthcare Choice Plus Buy-up

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	10% of Eligible Expenses	*30% of Eligible Expenses
8. Hospital - Inpatient Stay	10% of Eligible Expenses	*30% of Eligible Expenses
9. Injections Received in a Physician's Office	$15 per visit. No Copayment applies when a Physician charge is not assessed.	30% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	30% of Eligible Expenses 30% of Eligible Expenses
Outpatient Diagnostic/ Therapeutic Services -CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Therapeutic Treatments	10% of Eligible Expenses	30% of Eligible Expenses
12. Physician's Office Services	Preventive medical care: No copayment Sickness & Injury: $15 per visit, except that the Copayment for a Specialist Physician Office visit is $30 per visit. No Copayment for immunizations for children from birth to age five.	30% of Eligible Expenses 30% of Eligible Expenses No Copayment for immunizations for children from birth to age five.
13. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year. This limit does not apply to breast prostheses.	10% of Eligible Expenses	30% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	$15 per visit	30% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses
18. Transplantation Services	*10% of Eligible Expenses	*30% of Eligible Expenses Benefits are limited to $30,000 per transplant. Please note that this limitation does not apply to dose-intensive chemotherapy or bone marrow transplants.
19. Urgent Care Center Services	$50 per visit	30% of Eligible Expenses

UnitedHealthcare Choice Plus Buy-up

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
Additional Benefits		
Chemical Dependency Services Must receive prior authorization through the Mental Health/Substance Abuse Designee.	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Dental Anesthesia and Facility Charges	*Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Hearing Screenings for Newborns	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Mental Health Services Must receive prior authorization through the Mental Health/Substance Abuse Designee for Benefits. (This requirement is waived for the first two outpatient sessions.)	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Osteoporosis Treatment	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
PKU Formula	10% of Eligible Expenses	30% of Eligible Expenses
Spinal Treatment Copayments or coinsurance for Covered Health Services provided within the scope of a Chiropractor's license will not exceed 50% of the total cost of any single chiropractic service as defined by Missouri state law.	50% Deductible does not apply	50% Deductible does not apply

Exclusions

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings *Dental Services - Accident only* and *Dental - Anesthesia and Facility Charges*. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (not including hospitalizations and anesthesia for Covered Persons who meet the requirements) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Covered Persons with conditions outlined in (Section 1: What's Covered-Benefits) under *Dental-Anesthesia and Facility Charges*. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self- injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. This exclusion does not apply to the treatment of phenylketonuria or any inherited disease of amino or organic acids.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure.
(Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service -see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;

(2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends. This exclusion does not apply if you are eligible for and choose Continuation of Coverage. For more information, see Section 8 of the COC under the heading *Qualifying Events for Continuation of Coverage under State Law*.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

UnitedHealthcare® **Choice Plus Buy-Up Plan 100** **Coverage Period: 1/1/2013 – 12/31/2013**

Summary of Coverage: What This Plan Covers & What it Costs **Coverage for: Employee/Family** **Plan Type: PS1**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling the Member Service number listed on the back of your ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$200** Individual / **$400** Family Non-Network: **$400** Individual / **$800** Family. Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge"	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No, there are no other deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Network: **$1,000** Individual / **$2,000** Family Non-Net:work: **$2,000** Individual / **$4,000** Family. Other limits apply – see the chart that starts on page 2	The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services, prescription drugs and copays.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see **www.myuhc.com** or call the Member Service number listed on the back of your ID card for a list of network providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-741-8786 for Member Services or 1-866-336-9369 for Employer/Broker Services or visit us at www.myuhc.com. 1 of 7
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call the telephone numbers above to request a copy.

- **Co-payments** (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** (co-ins) is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an Network Provider	Your cost if you use an Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	50% co-ins for Manipulative (chiropractic) services*	50% co-ins for Manipulative (chiropractic) services*	*Deductible does not apply
	Preventive care / screening / immunization	No Charge	30% co-ins	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins	----------None----------
	Imaging (CT / PET scans, MRIs)	10% co-ins	30% co-ins	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay. Mail-Order: $20 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply. Tier 1 Contraceptives covered at No Charge. Plasma/blood products, focalin, depigmentation agents, photo aged skin, injectable cosmetics, hair growth, and PKU are not covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $20 copay. Mail-Order: $40 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $40 copay. Mail-Order: $80 copay	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	10% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Physician / surgeon fees	10% co-ins	30% co-ins	----------None----------
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	----------None----------
	Emergency medical transportation	10% co-ins	10% co-ins	----------None----------
	Urgent care	$50 copay per visit	30% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	10% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Physician / surgeon fees	10% co-ins	30% co-ins	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$15 copay per visit	30% co-ins	----------None----------
	Mental / Behavioral health inpatient services	10% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
	Substance use disorder outpatient services	$15 copay per visit	30% co-ins	----------None----------
	Substance use disorder inpatient services	10% co-ins	30% co-ins	Pre-Notification required for Non-Network benefits.
If you are pregnant	Prenatal and postnatal care	$15 copay	30% co-ins	Additional copays, deductibles, and co-ins may apply. Routine pre-natal care is covered at No Charge after first visit.
	Delivery and all inpatient services	10% co-ins	30% co-ins	Additional copays, deductibles, co-ins and Inpatient Notification may apply.
If you need help recovering or have other special health needs	Home health care	10% co-ins	30% co-ins	Limited to 60 days per policy period. Pre-Notification required for Non-Network benefits.
	Rehabilitation services	$15 copay per outpatient visit	30% co-ins	Depending on the type of therapy, there is a limit of 20-36 visits per policy period.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation Services.
	Skilled nursing care	10% co-ins	30% co-ins	Limited to 60 days per policy period, limit is combined with IP Rehabilitation

Common Medical Event	Services You May Need	Your cost if you use an Network Provider	Your cost if you use an Non-network Provider	Limitations & Exceptions
				Services. Pre-Notification required for Non-Network benefits.
	Durable medical equipment	10% co-ins	30% co-ins	$2,500 maximum per policy period if the benefit/device is determined to be non-essential. Pre-Notification required for DME over $1,000 or no coverage.
	Hospice service	10% co-ins	30% co-ins	Limited to 360 days during the entire period of time on the policy. Pre-Notification required for Non-Network benefits
If your child needs dental or eye care	Eye exam	$15 copay per visit	30% co-ins	1 exam every 2 years
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult/Child)	• Glasses • Habilitative Treatment • Infertility Treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Routine eye care (Adult) – may be covered with limitations	• Hearing aids – may be covered with limitations	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323x1565 or visit http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to *appeal* or file a *grievance*. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com or California Department of Insurance at 1-800-927-4357 or visit http://www.insurance.mo.gov

Additionally, a consumer assistance program may help you file your appeal. Contact Missouri Department of Insurance, Consumer Affairs Division at 1-800-726-7390. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

- Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
- 若需要中文协助，请拨打您会员卡上的电话号码
- Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
- Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan pays** $6,720
- ☐ **You pay** $820

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$200
Co-pays	$40
Co-insurance	$430
Limits or exclusions	$150
Total	**$820**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan pays** $4,300
- ☐ **You pay** $1,100

Sample care costs:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$160
Co-pays	$860
Co-insurance	$0
Limits or exclusions	$80
Total	**$1100**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-741-8786 for Member Services or 1-866-336-9369 for Employer/Broker Services or visit us at www.myuhc.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call the telephone numbers above to request a copy.

Urgent Care Centers

Urgent Care Centers are becoming more common in the St. Louis area which is a great benefit for all employees. You should use Urgent Care Centers for conditions like sprains, strains, headaches, burns, ear infections, minor broken bones (fingers), minor infections, rashes, coughs, colds and flu and sore throats. The waiting time for Urgent Care is less than half the time you will wait in the Emergency Room. Emergency Room care is essential in some cases and must be utilized. If you have any questions regarding the need for emergency care, please contact UnitedHealthcare at 1-888-887-4114 to speak with a registered nurse 24/7. To find the closest Urgent Care center to you, visit myuhc.com and click on the "Find Physician, Lab, or Facility" link.

Following is a listing of Urgent care Centers in and around the City of St. Louis that are currently in the UnitedHealthcare Network. Please contact them directly for hours of operation. Before you make an appointment, always check that the doctor or facility participates in your network. To find out, you can ask your doctor or facility or you can check on **myuhc.com**.

After Hours Pediatric Urgent Care
102 LAURA K DR
O FALLON, MO 63366
(636) 379-9633

1751 CLARKSON RD
CHESTERFIELD, MO 63017
(636) 519-9559

Anderson Express Care
1103 BELT LINE RD
COLLINSVILLE, IL 62234
(618) 344-2273

17 GINGER CREEK MEADOWS
GLEN CARBON, IL 62034
(618) 656-9777

2504 COMMERCE
HIGHLAND, IL 62249
(618) 651-9777

Concentra Urgent Care Pa
128 MATRIX COMMONS DR
FENTON, MO 63026
(866) 944-6046

1551 WALL ST STE 100
SAINT CHARLES, MO 63303
(866) 944-6046

1617 S 3RD ST
SAINT LOUIS, MO 63104
(866) 944-6046

463 LYNN HAVEN
HAZELWOOD, MO 63042
(866) 944-6046

6726 MANCHESTER RD
SAINT LOUIS, MO 63139
(866) 944-6046

83 PROGRESS PKWY
MARYLAND HEIGHTS, MO 63043
(866) 944-6046

8340 N BROADWAY
SAINT LOUIS, MO 63147
(866) 944-6046

Doctors Express
11648 MANCHESTER RD
SAINT LOUIS, MO 63131
(314) 821-1099

Downtown Urgent Care
623 W 5TH ST
EUREKA, MO 63025
(636) 549-2100

916 OLIVE ST STE 2
SAINT LOUIS, MO 63101
(314) 436-9300

DRX East Missouri Providers PC
747 N NEW BALLAS RD
SAINT LOUIS, MO 63141
(314) 991-3030

Express Medical Care
5031 N ILLINOIS ST
FAIRVIEW HEIGHTS, IL 62208
(618) 212-6800

Integra Physicians Urgent Care Centers L
12161 MANCHESTER RD
SAINT LOUIS, MO 63131
(314) 965-7800

Jefferson Health Urgent Care
1400 HIGHWAY 61 S
CRYSTAL CITY, MO 63019
(636) 933-1669

Ofallon Urgent Care
2630 HIGHWAY K
O FALLON, MO 63368
(636) 980-5300

Patients First Urgent Care
20 THE LEGENDS PKWY
EUREKA, MO 63025
(636) 459-0100

Samc Urgent Care Center LLC
10296 BIG BEND BLVD
SAINT LOUIS, MO 63122
(314) 543-5970

2900 LEMAY FERRY RD STE 101
SAINT LOUIS, MO 63125
(314) 543-5294

3619 RICHARDSON SQ DR
ARNOLD, MO 63010
(636) 717-6700

714 GRAVOIS RD STE 100
FENTON, MO 63026
(636) 326-6100

St Louis Connectcare
5535 DELMAR BLVD
SAINT LOUIS, MO 63112
(314) 361-1212

St Elizabeth's Urgent Care
1512 N GREEN MOUNT RD
O FALLON, IL 62269
(618) 624-3750

St Luke's Urgent Care
1051 WOLFRUM RD
WELDON SPRING, MO 63304
(636) 300-0370

11550 OLIVE BLVD STE 100
SAINT LOUIS, MO 63141
(314) 542-7690

233 CLARKSON RD
ELLISVILLE, MO 63011
(636) 256-8644

455 S KIRKWOOD RD
KIRKWOOD, MO 63122
(314) 965-6871

508 OLD SMIZER MILL RD
FENTON, MO 63026
(636) 343-5223

5551 WINGHAVEN BLVD STE 100
O FALLON, MO 63368
(636) 695-2500

Total Access Urgent Care PC
9556 MANCHESTER RD
SAINT LOUIS, MO 63119
(314) 961-2255

Wentzville Med-Ped Urgent Care LLC
2070 MCKELVEY RD
MARYLAND HEIGHTS, MO 63043
(314) 434-1900

2893 VETERANS MEMORIAL PKWY
SAINT CHARLES, MO 63303
(636) 724-1100

Specialty centers with any quality designation and average or higher cost efficiency are eligible for the highest benefit. This is included in benefit plans where facility tiering is available for cardiac care, cardiac surgery, hearth rhythm disorders, total joint replacement or spine surgery.

SLPS "Be Well" Wellness Program

In 2009, SLPS rolled out its first wellness plan in order to help our employees either stay healthy and/or become healthy. We are so impressed with the last three years of success and participation and want to continue the momentum into 2013 and beyond. We will continue to partner with UnitedHealthcare for 2013 in order to deliver a comprehensive wellness plan to our district employees.

For the 2013 wellness plan year, you will need to complete TWO steps in order to be considered a wellness participant and avoid being charged a non-participation fee. The TWO steps you will have to complete are:

STEP 1: Biometric Screening – this is a non-fasting finger prick blood draw which will test for Total Cholesterol, HDL, Ratio of Total Cholesterol to HDL, and Glucose.

STEP 2: Health Risk Assessment – this is a questionnaire which will include questions about your health-related lifestyle and results from your Biometric Screening.

Details surrounding Steps 1 and 2 of the 2013 wellness plan will be released at a later date.

The 2013 wellness plan will continue to include the following benefits:

1. **Online or Telephone-based Health Coaching Program** – services focus on losing weight, quitting smoking, exercising more, relieving stress, and more.
2. **Incentives/Rewards** – ability to earn gift cards for taking steps to understand and improve your health and well-being! See information in the box below. However, you have the right to waive participation in the gift card program.

IMPORTANT NOTICES:

1. The *Know Your Numbers Biometric Screenings and Health Risk Assessment* campaign will take place in the first half of 2013 with specific dates to follow. Employees who do not participate in these programs will be charged a small portion of the monthly medical premium.
2. Due to legal restrictions, UnitedHealthcare will not release any personal screening or assessment results to St. Louis Public Schools. Therefore, all personal and member-specific information is confidential.
3. Taxation for gift cards will appear on your last paycheck of the year.
4. Additional information regarding the SLPS Be Well program can be found on the District's intranet site.

Activity	Reward Amount*	Who participates†	When you do this
Preventive Care Services	$75	Employees and spouses covered by this UnitedHealthcare plan	Annually
Health Coaching Program	$25	Employees and spouses covered by this UnitedHealthcare plan	After completing the online Health Assessment
Telephone-based Health Coaching	$75	Employees and spouses covered by this UnitedHealthcare plan. *Telephone-based coaching is more complex and time consuming and may be more appropriate for people with more serious health conditions.*	After completing the online Health Assessment

* Maximum reward per employee $175; Maximum reward per family $350. Each Employee and Spouse is eligible to receive a maximum of one reward for completing the wellness activity listed in each category. This includes a maximum of one reward per person for completing the Health Assessment, one for online coaching and one for telephone-based coaching.

† Children may not participate in the reward program.

Watch for more SLPS "Be Well" communications regarding how to improve your health.

Care24 Services

Care24 is a confidential free service which offers you access to a wide range of health and well-being information – seven days a week, 24 hours a day. Using one toll-free phone number, you can speak with registered nurses and master's-level counselors who can help with almost any problem ranging from medical and family matters to personal, legal*, financial and emotional needs.

Connecting people with information they need

Care24 Services connect people with reliable resources for information and support regarding a wide range of personal concerns – 24 hours a day, 365 days a year.

One toll-free phone number gives you access to experienced professionals:

- Registered nurses
- Master's-level counselors
- Legal and financial professionals
- Community resources

When you call the same toll-free number, you can listen to audio messages on more than 1,100 health and well-being topics. To listen to your message of choice, press * to speak with a nurse who will provide you with information on the health topics along with the three-digit access PIN number. More than 600 audio messages are recorded and available in Spanish, along with multi-lingual translation services, and service for callers with hearing impairments.

Expanded support

If face-to-face resources are appropriate for your situation, a Care24 representative can refer you to local, in-person support. Counselors also can refer you to a wide range of national and community resources.

24-hour convenience

Care24 nurses and counselors help you and your family identify and address concerns that span the spectrum of work and life.

Current health and well-being information

Care24 nurses and counselors offer service based on up-to-date medical and professional guidelines. We consistently deliver high-quality service, so you can be confident that you and your family receive reliable health, personal legal and financial information you can use every day.

How to call

To take advantage of Care24 Services, nurses and counselors are available 24 hours a day, 7 days a week. Call 1-888-887-4114. TTY/TDD callers, please call the National Relay Center at 1-800-828-1120 and ask to be connected to the 800 number listed above.

* Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving Optum services directly or indirectly (e.g. employer or health plan).

- **Childhood illnesses**
- **Minor illnesses and injuries**
- **Medication safety**
- **Relationship worries**
- **Choosing appropriate medical care**
- **Stress and anxiety**
- **Coping with grief and loss**
- **Personal legal and financial issues**
- **Self-care information**
- **Help Finding a doctor**
- **Information on medications**
- **General Health Information**

Prescription Drug Benefits

The cost of prescription drugs is increasing rapidly - resulting in higher expenses for the District. Using your prescription drug benefit effectively by requesting generic drugs will help both you and the District manage expenses. The prescription drug program is self-funded by the District and currently administered by Express Scripts.

Prescription drugs are available to you for a co-payment that is dependent on the retail cost to the plan. This allows you and your physician to research the cost of various drugs that may be of benefit to you and determine the cost of the various drug options available to you.

The chart below compares your prescription drug benefits under the Choice Plus Base and Choice Plus Buy-up plan options.

	Participants in UnitedHealthcare Choice Plus Base	Participants in UnitedHealthcare Choice Plus Buy-up
Prescription Drugs		
Co-pay at Participating Retail Pharmacies	$10* (drug cost of $10-$40) $25 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)	$10* (drug cost of $10-$40) $20 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)
Co-pay for Mail Service or selected pharmacies (up to a 90-day supply)	$20 (drug cost of $20-$80) $50 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)	$20 (drug cost of $20-$80) $40 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)

*If the actual cost of the drug is less than the co-pay, you pay actual cost.

Don't Forget!

The prescription drug plan will provide for a voluntary prescription drug savings program that allows members the option of replacing high cost brand drugs with over-the-counter (OTC) and generic alternatives.
The OTC program will cover over-the-counter equivalents of high cost and highly utilized drugs in the following three drug classes: PPI's (acid reducers, e.g. "Nexium"); NSAID's (non steroidal anti-inflammatory drugs, e.g., "Celebrex"); and Antihistamines (e.g., brand drug Clarinex; OTC drug Claritin). The program will feature a zero ($0) co-pay for members able to use an OTC alternative with a physician's prescription.

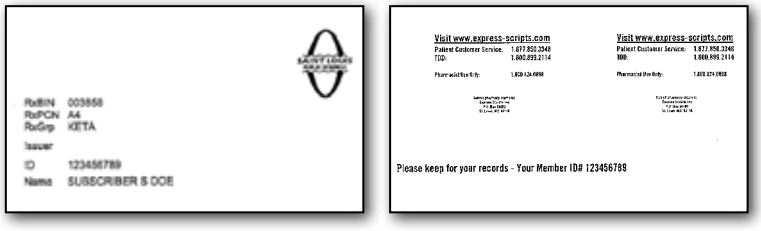
Special Note:

Retail 90-day supplies of maintenance medications can be filled at any in-network pharmacy location or by mail order via **www.express-scripts.com**. Click on "members"and register on the website. Once registered, follow the instructions to request prescriptions by mail.

The National Pharmacy network contains over 50,000 pharmacies which contain both chain pharmacies and independent pharmacies.

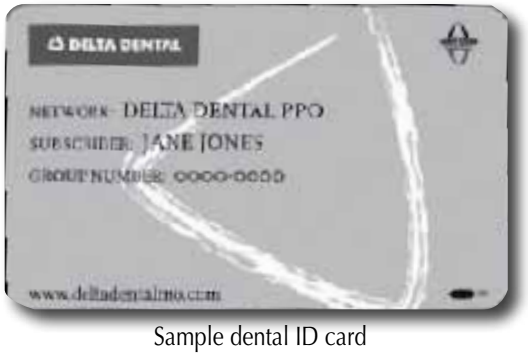
Examples of in-network Chain Pharmacies: Medicine Shoppe, Schnucks, Walgreen's, Wal-Mart, Target and K-Mart.

Pharmacy Locator services are available by contacting customer service at **1-877-850-3340** or by logging onto **www.express-scripts.com**. Once you have logged in, click "My Prescription Plan" and then click "Locate Pharmacy."



Sample pharmacy ID card

Dental Plan



Sample dental ID card

Delta Dental coverage helps you and your family with the cost of maintaining good dental health and treating dental disease or injury.

Your personal enrollment worksheet lists the options available to you, along with each option's cost per pay period.

	PPO	Premier	Out of Network
Deductible		Waived for Preventative & Ortho	
• Individual	$0	$100	$100
• Family	$0	$300	$300
Coinsurance			
• Preventative	100%	90%	70%
• Basic	80%	60%	50%
• Major	50%	40%	20%
Periodontics Covered Under		Basic	
Endodontics Covered Under		Basic	
Oral Surgery Covered Under		Basic	
Annual Maximum	$2,500	$1,500	$1,000
Orthodontia	50% to $1,000	50% to $1,000	50% to $1,000
Waiting Periods		None for Timely Entrants	
Out of Network UCR		Maximum Plan Allowance	
Dependent Age Limit		26	

PPO Network Dentists	Accept lower fee allowances and do not bill the patient for amounts over the PPO fee allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients - saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to PPO network dentists.

Premier Network Dentists	Accept the Premier network contracted allowance and do not bill the patient for amounts over the contracted allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients- saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to Premier network dentists.

Dentists not in a Delta Dental Network	Are reimbursed up to the allowed amount of what dentists charge in the same geographic area and with the same specialty.
	Bill the patient for ALL amounts not covered by the plan.
	Are not under contract to file claims for the patient.
	Benefit payments for non-network dentists are made to the member.

Vision Plan

The Vision Plan provides coverage for basic vision care services for you, and if applicable, your eligible family members. The plan is offered through Vision Benefits of America (VBA). You can search for VBA providers at **www.visionbenefits.com**.

Your personal enrollment worksheet lists your vision options and associated costs per pay period.

	In-Network Provider	Out-of-Network Provider	
	You Pay	***You Pay***	***Plan will reimburse up to****
Examination	$10	100%	$36
• Lenses	$10		
• Single Vision		100%	$28
• Bifocal		100%	$45
• Trifocal		100%	$56
• Lenticular		100%	$80
• Polycarbonate (under age 19)		100%	$0
• Tinted (pink #1 or #2 only)		100%	$0
Frames	$10	100%	$45
Contact Lenses (evaluation and fitting)			
• Medically Necessary	Usual, Reasonable and Customary	100%	$210
• Elective	$105	100%	$105

* You will also pay a co-pay equal to the in-network co-pay amount.

Vision examinations are allowed once each 12 months.

New frames will be provided once each 24 months.

New lenses or contacts will be provided once each 24 months.

Special Note:
VBA is a voucher program. When you are ready to use this benefit, you will need to obtain a vision authorization by calling **1-800-432-4966** or by logging on to the Vision Benefits of America website at **www.visionbenefits.com**.

Providers that do not require an authorization voucher are noted on the Vision Benefits website.

Vision Plan -Board of Education City of St. Louis

VISION BENEFITS OF AMERICA (VBA) maintains a network of more than 15,000 Participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

What are the benefits?

VISION EXAMINATION - A complete analysis of the eyes and related structures to determine the presence of any vision problems.

- SPECTACLE LENSES-Your program provides the finest quality lenses fabricated to VBA's exacting standards. A VBA Participating Provider will order the proper lenses and verify their accuracy when finished.
- FRAMES-VBA plans offer a wide selection of fully covered designer frames; however, if you choose a frame which costs more than the amount allowed by your plan, you will be responsible for any additional controlled charges.

-or-

- CONTACTS SELECTED IN LIEU OF GLASSES-When contact lenses are selected in lieu of glasses, your plan will provide a total allowance of up to $105.00 toward their cost. THIS IS IN LIEU OF ALL OTHER BENEFITS FOR THE BENEFIT PERIOD. YOU WILL NOT RECEIVE ANY ADDITIONAL MONIES FOR CONTACT LENSES AND/OR CONTACT LENS EXAM COSTS THAT ARE MORE THAN THE $105.00 ALLOWANCE.

MEDICALLY NECESSARY CONTACT LENSES-Contact lenses are fully covered on a UCR* basis when a VBA Participating Provider receives prior approval for one of the following services related to eye disease or injury:

a) Following cataract surgery
b) To correct extreme visual acuity problems not correctable with spectacle lenses
c) To correct for significant anisometropia
d) To correct for keratoconus

- LASIK - All VBA covered subscribers are eligible to receive a significant discount at hundreds of provider locations nationwide. For more information regarding this benefit, please call VBA's Customer Service at 1-800-432-4966/option 5.
- Usual, Customary, Reasonable as determined by VBA.

*See Extra Cost and Non-Covered items as outlined in Section VI.

How often are these services available? (from the last date of service)

EXAMINATION: Once every 12 months
LENSES: Once every 24 months
FRAMES: Once every 24 months
-or-
CONTACT LENSES (in lieu of all other benefits for the benefit period): Once every 24 months

How much do I pay?

When you choose to obtain services from a VBA Participating Provider, this plan covers the benefits described herein (examination, professional services, lenses and frames) at no expense to you, if the materials selected fall within your plan's allowance. A $10 copayment applies to the vision exam and a $10 copayment applies to the total cost of the lenses and/or frames selected through a VBA Participating Provider only. The copayment (s) do not apply to the contacts.

How do I use this plan?

Prior to receiving vision benefits, you can easily check your eligibility and find a VBA Provider near your area by doing one of the following:

- Call VBA at 1-800-432-4966/push "1" then "5" and a VBA service representative will answer all of your questions, including helping you find a provider who would accept VBA's paperless E-Claims system - where you do not need a paper benefit form.

-or-

- Visit VBA's website at www.visionbenefits.com and obtain the same information, including providers with their names emboldened if they accept VBA's E-Claims system. When making your paperless claims appointment, please let the office know that you would like to use the VBA E-Claims system.

-or-

- If you prefer to use VBA's paper benefit form, simply call the same number, or visit the same website, and follow the instructions to request the VBA benefit form, which will be mailed directly to your home, along with a printed list of all VBA providers in your area.

Option I

If You Select the VBA Benefit Form and use a VBA Participating Doctor:

1. Choose a VBA Participating Doctor from the printed roster and make an appointment for the eye examination.
2. You MUST present the benefit form to the VBA Participating Doctor on your first visit. Failure to do so will result in your being partially reimbursed according to the Non-Participating Provider Reimbursement Schedule. When the examination has been completed, the VBA Participating Doctor will have you sign the benefit form and pay the copayment(s), if applicable.
3. The VBA Participating Doctor will take care of all paperwork for payment. VBA will pay the Doctor for the services you received according to VBA's contractual agreement with the Doctor.

Option II

If You Choose to See an Optometrist, Ophthalmologist or Dispensing Optician Who Is Not A VBA Participating Provider:

1. Make an appointment and receive the necessary services from the provider. Pay the Provider his full fee and obtain an itemized receipt which must contain the following information:

Vision Plan -Board of Education City of St. Louis

a) Patient's name
b) Date services began
c) The services and/or materials the patient received
d) The type of lenses the patient received (single vision, bifocal, etc.)

2. Mail your VBA Benefit Form and itemized receipts to:
   VISION BENEFITS OF AMERICA
   300 Weyman Plaza, Suite 400
   Pittsburgh, PA 15236-1588
3. You will be reimbursed directly according to the following Reimbursement Schedule:

Non-participating provider reimbursement schedule

PROFESSIONAL FEES	
Vision Examination, up to	$ 36.00
OPHTHALMIC MATERIALS	(pair)
Single Vision Lenses, up to	$ 28.00
Bifocal Lenses, up to	45.00
Trifocal Lenses, up to	56.00
Lenticular Lenses, up to	80.00
One Year Scratch Protection	N/A
Polycarbonate Lens Material	N/A
Frames, up to	$ 45.00

-or-

CONTACT LENSES (In lieu of all other benefits for the benefit period. You will not receive any additional monies for contact lenses and/or contact lens exam costs that are over the allowance).

Elective (In Lieu of Glasses)	$ 105.00
Medically Necessary	210.00

THERE IS NO ASSURANCE THE NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, GLASSES OR CONTACTS.

Option III

If You Choose to See A Non-Participating Provider For An Eye Exam and Have A VBA Participating Provider Fill Your Prescription:

1. After receiving an eye exam from the Doctor, pay the Doctor his exam fee. Obtain a receipt for the exam and the prescription for your lenses.
2. Call one of the VBA Participating Providers who has an asterisk beside their name (this means they are willing to fill another Doctor's prescription) and make an appointment to have your prescription filled/lenses made.
3. Take your VBA Benefit Form and your prescription to the VBA Participating Provider on your first visit. They will fit you with your new glasses and take care of any paperwork associated with the glasses. The Participating Provider will be paid by VBA for all covered services.
4. You will be paid directly for your eye exam according to the above Reimbursement Schedule. Simply submit the paid exam receipt to VBA and indicate your employer's name and the employee's ss#.

NOTE: If any problems arise with your glasses or contacts due to an inaccurate prescription written by a Non-Participating Provider, VBA and our Participating Provider assume no responsibility.

Who is eligible?

The employee, as well as his or her dependents (if dependent coverage is provided). Eligible dependents would include the spouse and dependent children. Please check with your employer for age limits.

What optional vision materials are available at controlled pricing under this plan?

EXTRA COST--This plan is designed to fully cover your visual needs rather than cosmetic lens & frame options. There will be controlled extra costs involved if you select any of the following:

a) Rimless frames
b) A frame that costs more than your plan's allowance
c) Elective contact lenses (in excess of your plan's allowance)
d) Progressive lenses (available starting at $45.00)
e) Polycarbonate lens material for adults (covered if under 19)
f) Photosensitive lenses (glass or plastic)
g) Tinted lenses
h) Coated lenses (except 1 yr scratch protection is included)

NOT COVERED ITEMS--There are no benefits for professional services or materials connected with:

a) Orthoptics or vision training, subnormal vision aids or non-prescription lenses.
b) Lenses and frames furnished under this program which are lost or broken. These will not be replaced unless you are eligible for frames or lenses at that time.
c) Medical or surgical treatment of the eyes.
d) Two pairs of glasses in lieu of bifocals.
e) Services or materials provided as a result of any Workers' Compensation Law or similar legislation.
f) Any eye examination required by an employer as a condition of employment; or any services or materials provided by any other vision care plan, or group benefit plan containing benefits for vision care.

IF YOU HAVE QUESTIONS ABOUT YOUR VISION CARE COVERAGE OR THE FILING OF YOUR CLAIM, PLEASE CONTACT THE CUSTOMER SERVICE DEPARTMENT AT 1-800-432-4966.

VBA#670 09/12

Basic & Supplemental Life Benefits

- Additional Services available to St. Louis Public School Employees are: Will and Trust Preparation Services and Beneficiary Services. Information on both of these benefits is located on pages 46 and 47.
- Company Paid Basic Life and Accidental Death and Dismemberment (AD&D)
- Voluntary Employee Supplemental Life, Supplemental Dependent Spouse and Child Life Plan

Employee Basic Life	Eligibility	All Active Full-Time Employees (excludes Superintendents)
	Life and AD&D Benefit	$40,000
	Guarantee Issue	$40,000
Eligibility - Supplemental Life Employee and Dependent		All Active Full-Time Employees
Employee Supplemental Life	Life Benefit	$5,000; $10,000; $20,000; $50,000; $75,000; $100,000; $125,000; $150,000; or $200,000
	Guarantee Issue	$200,000
Employee Coverage Provisions	Benefit Reduction	No age reductions Coverage ceases at retirement
	Accelerated Death Benefit	Up to 75% of life benefit not to exceed $200,000 is payable if life expectancy is 12 months or less
	Waiver of Premium	To age 65 if disabled prior to age 60 and the disability lasts at least 6 months
	Portability	The lesser of the Employee's combined in force Basic and Supplemental life amounts or $240,000
Dependent Supplemental Life	Spouse Life Benefit	$10,000 to $100,000 in increments of $10,000 not to exceed 50% of employee's supplemental life amount (Example: If employee elects $20,000, the Spouse cannot elect more than $10,000)
	Child Life Benefit (14 days of age to age 26)	$5,000; $7,500; or $10,000
	Guarantee Issue	Spouse: $20,000 Child(ren): $10,000
	Portability	The lesser of the Dependent's in force supplemental life amount or $100,000

- Limitations for AD&D: Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.
- This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.
- Late applicants are subject to Evidence of Insurability.

This is an overview of your benefits. The contract will govern actual benefits. The Company reserves the right to make future changes.

Supplemental Life Benefit

You may enhance your District-provided Basic Group Term Life Insurance by electing Supplemental Life Insurance. This coverage provides an additional benefit to your beneficiary(ies) if you die while insured. Your personal enrollment worksheet lists the options available to you, along with each option's cost per pay period. You pay the cost of this benefit on an after-tax basis.

Premium Calculation Examples:

Supplemental Life

- Employee, age 36: $200,000 x $0.208 = $41,600 / $1,000 = $41.60 per month
- Spouse, age 33: $20,000 x $0.208 = $4,160 / $1,000 = $4.16 per month
- Child(ren): $10,000 x $0.15 = $1,500 / $1,000 = $1.50 per month

(**Note:** monthly premium is the same regardless of the number of dependent children covered)

Your Cost at a Glance

Employee Basic Life and AD&D	100% Company Paid
Supplemental Life	$0.208 per $1,000
Employee and Spouse (requires 20% participation)	
Supplemental Child Life	$0.15 per $1,000

Depending on your situation, you may be required to provide Evidence of Insurability (EOI) when you enroll for Supplemental Life Insurance coverage, according to the following rules:

- If you are a newly hired employee, you may elect any coverage level listed on page 44 without providing EOI.
- Current employees enrolling for the first time must show EOI when selecting any level of coverage.
- Current employees who previously enrolled for coverage may increase their coverage by one level -for example, elect to increase from $10,000 to $20,000 - without providing EOI. However, EOI will be required for all increases of more than one coverage level.
- If you experience a qualified life event or change in status, you may make changes to your Supplemental Life Insurance coverage that are consistent with and on account of your change in status. If you are enrolling for the first time, you may elect coverage of $5,000 without providing EOI. You must show EOI when selecting any other level of coverage for the first time. If you are already enrolled for coverage, you may increase your coverage by one level without providing EOI. However, EOI will be required for all increases of more than one coverage level.

If your Supplemental Life Insurance selection requires you to provide EOI, you will receive a a pop-up during online enrollment, if you enroll by phone the required forms will be mailed to you. You will need to complete and return this form to: St. Louis Public Schools, Human Resources, 801 North 11th Street, St. Louis, MO 63101, Attn: Karen Shelton-Henry—Benefits/EOI enclosed. If your coverage selection is approved, your coverage will be effective the first of the month following approval and the appropriate payroll deductions will be taken.

CIGNA's Will Preparation Program

CIGNA makes it easy for you to take charge of those difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with our online will preparation services. Available to individuals who have CIGNA's Group life, accident, or disability coverage.

Think you don't need a will or living will?

If you're like most people, you don't like thinking about planning for your death. However, there are many good reasons why it's very important to have a will no matter what your personal circumstances might be. For example, to have a say in your healthcare treatment if you're not able to speak for yourself, to assign guardianship for minor children, and to secure your assets.

Think you don't have enough assets to need a will?

Nearly one in four (24%) of American adults say their biggest reason for not having a will is a lack of sufficient assets.[1] Not having a will puts your family in the position of having to guess about how to manage your personal and financial assets after your death.

Think you can't afford to create a will?

Now you can! CIGNA's Will Center allows you to easily complete essential life and health legal documents online at no cost to you.

Not sure how to develop your will?

Don't worry. CIGNA's Will Center is secure, easy to use, and available to you and your covered spouse seven days a week, 365 days a year. And, if you have any questions, phone representatives are available to assist you via a toll-free number.[2] Once registered on the site, you will have direct access to a Personal Estate Planning web page, where you can:

- create and maintain your personalized legal documents
- follow an intuitive, interactive, question-and-answer process to create state-specific legal documents tailored to your situation
- preview, edit, download and print your legal documents for execution

It's easy! Go to CIGNAWillCenter.com

To access your Personal Estate Planning web page, simply complete the online form and register as a new user. When prompted for a registration code, provide your date of birth plus the last four digits of your Social Security number. Once this is completed you can immediately start building your will and other legal documents.

Now is the time to get started.

Visit CIGNAWillCenter.com to create your own personalized:

Last Will & Testament – specifies what is to be done with your property when you die, names the executor of your estate and allows you to name a guardian for your minor children.

Living Will – contains your wishes regarding the use of extraordinary life support or other life-sustaining medical treatment.

Healthcare Power of Attorney – allows you to grant someone permission to make medical decisions if you are unable to make them yourself.

Financial Power of Attorney – allows you to grant someone permission to make financial decisions on your behalf if you are unable to make them yourself.

Medical Authorization for Minors – allows you or a guardian to provide authorization for medical personnel to treat your child in the event you are not present.

Plus, find information on:

- **Estate Planning**
- **Identity Theft Information Kit**
- **CIGNA's Life and Disability Planning Kits** – access insurance calculators to determine whether you and your family have sufficient coverage for the future.

1 National Association of Estate Planners and Councils. "Wills 101: Everything You Know But Don't Want to Think About." June 2006.
2 No legal advice is provided.

The CIGNAssurance® Program for Beneficiaries

Providing peace of mind at a time of need

Through CIGNA's broad employee benefits capabilities and expertise, we are able to provide a package of financial, bereavement and legal services to help Life and Personal Accident[1] beneficiaries. The CIGNAssurance Program gives employees greater peace of mind that insured loved ones will have the support they need following their loss.

The CIGNAssurance Program provides:

Bereavement counseling with professional behavioral health experts

- Access to free, confidential bereavement services by phone 24 hours a day, 7 days a week
- Two free face-to-face counseling sessions with CIGNA Behavioral Health experts
- Assistance finding community-based programs including self-help groups, educational programs, nonprofit organizations and public resources

Legal assistance from licensed, practicing attorneys

- Up to 30 minutes of free telephone legal consultation services
- Referral to discounted, professional legal services for help settling the estate, preparing
- Will or receiving general legal advice (25 percent off usual and customary charges)

Guidebook helps beneficiaries navigate legal and financial responsibilities

- Provides information on probating the estate, investigating additional benefit sources, and financial assessment and planning
- Includes sample letters that beneficiaries can use in their search for additional benefits; downloadable, customizable versions of letters are available at **www.cigna.com**

it's time to *feel better*

Expert financial guidance

- Up to 30 minutes of free telephone consultation with professionals who have extensive experience in financial services (including Certified Public Accountants, Certified Financial Planners, Chartered Financial Consultants, Registered Investment Advisors, Chartered Life Underwriters, Stockbrokers and Personal Financial Specialists)
- Referrals to financial professionals who can assist beneficiaries with additional financial needs[2]

CIGNAssurance account

- Benefits over $5,000 are deposited into a free interest-bearing account with draft privileges;[3] this gives beneficiaries the time to deal with more pressing issues and helps provide peace of mind that their money is still working for them

1 These services are available to beneficiaries once they have received benefit checks over $5,000 from CIGNA Group Insurance Life and Personal Accident Programs. Phone and face-to-face counseling sessions must be used within one year of the date the claim is approved.

2 Additional charges may apply.

3 This account, called CIGNAssurance®, is not a bank deposit and is not FDIC Insured.

CIGNAssurance provides beneficiaries with:

- Bereavement counseling with certified specialists
- Financial information from experienced professionals
- Legal consultation services

The CIGNAssurance package to beneficiaries includes:

- "Where To Go From Here" brochure
- "Looking Ahead" guidebook
- Personalized book of drafts
- **Certificate of confirmation**

Flexible Spending Accounts

Under the Flexible Spending Account (FSA) Plan, you may elect to set aside pre-tax dollars to pay for certain benefits expenses, Healthcare Reimbursement (Healthcare FSA) and/or Dependent Care Reimbursement (Dependent Care FSA). This Plan helps you because the benefits expenses you elect are nontaxable, which means that:

- Pre-tax contributions are withheld from your gross income before any applicable federal, state and local taxes have been deducted and
- You save Social Security and income taxes on the amount of your salary that you contribute to the plan. As a participant in the FSA Plan, pre-tax contributions are deducted from each paycheck (24 deductions for 12-month employees and 20 deductions for non 12-month employees) for the upcoming plan year. These deductions will appear as a credit to your FSA. As you incur eligible expenses, you will submit a claim form to be reimbursed from your account.

Healthcare FSA

The Healthcare FSA is a way for you to pay with tax-free dollars for many of your health-related out-of-pocket expenses that are not covered or fully reimbursable under your medical plan. Examples of expenses for which you may be reimbursed are those that are incurred for physician office visit co-pays, prescription co-pays, vision care expenses and even certain Over-the-Counter (OTC) drugs and medicine.

However, federal regulations do not allow any insurance premiums, warranties, service contracts, or long-term care expenses to be reimbursed under this plan.

***Certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription or Letter of Medical Need from your physician. Be sure to visit https://portal.adp.com for regular updates about OTC eligibility.**

Examples of Eligible Healthcare Expenses

- Medical plan deductibles
- Most co-payments
- Prescription drugs
- Over-the-counter (OTC) drugs and medicines purchased to alleviate or treat personal injuries or sicknesses*
- Routine checkups and physicals
- Dental and orthodontia expenses
- Vision care expenses, including exams, glasses, and contact lenses
- Laser eye surgery
- Many treatments for alcoholism or drug addiction
- Weight loss programs prescribed to treat an existing disease
- Smoking cessation programs and prescriptions prescribed by a physician
- Psychology and Psychoanalysis medical expense amounts
- Medically necessary cosmetic surgery
- Hearing Aids/batteries
- Birth control pills, devices and procedures
- Sterilization & Vasectomy
- Well baby care and immunizations
- Occupational/Physical therapy
- Chiropractor expenses for medical care
- Infertility treatments
- Massage therapy used to treat injury or trauma
- Acupuncture or related procedures when treating a medical condition

You may choose any annual Healthcare Reimbursement amount you desire, subject to the following minimum and maximum annual amounts

Payroll Schedule	Annual Minimum	Minimum Per Pay Period	Annual Maximum	Maximum Per Pay Period
12-Month	$240	$10.00	$1,500	$62.50
Non-12-Month	$240	$12.00	$1,500	$75.00

Eligible medical expenses must be incurred during the Plan Year (or the 2½ month Grace Period thereafter) and while you are a participant. You may not be reimbursed for any expenses arising before the Healthcare FSA becomes effective or for any expenses incurred after the close of the Grace Period or after a separation from employment.

If you do not incur an amount of eligible medical expenses that match the pre-tax dollars set aside and allocated to your account, the allocated amount is forfeited.

If you are a newly eligible or newly enrolled participant in the Flexible Spending Account Plans, your annual amount will be divided by the number of remaining pay periods for the calendar/plan year.

Flexible Spending Accounts

Dependent Care FSA

The Dependent Care FSA allows you to pay for qualifying dependent care expenses with tax-free dollars for eligible reimbursable dependent care expenses. Qualifying dependent care expenses are those expenses that you incur in order for you and your spouse to work or look for work during your period of coverage.

Dependent care expenses are limited to:

- Care for dependent children under age 13, who have the same principal place of abode as you and who do not provide over half of their own support, or
- A spouse or a dependent who is physically or mentally incapable of caring for himself or herself, for whom the Participant provides over one-half of the individual's support for year, and whose gross income is less than the federal tax exemption amount (currently $3,200).

Note: There is a special rule for children of divorced parents. Dependent care expenses are limited to those of the parent with whom the child resides with the longest during the year.

You'll need to get the taxpayer identification number from the facility providing care for your dependent. If an individual provides care for your dependent, a Social Security number is acceptable. The individual must report the income in order for you to get the tax advantage of using the dependent care reimbursement account.

Ineligible dependent care expenses include:

- Expenses claimed as deductions or credits on your federal income tax return
- Expenses for food, clothes, or transportation
- Expenses for the education of a dependent in the first or higher grade level
- Expenses for the care of your physically or mentally incapacitated spouse or dependent who doesn't spend at least eight hours each day in your home
- Expenses for care provided by a family member if that person is claimed as a dependent on your income tax form or under age 19

You may choose any annual Dependent Care Reimbursement amount you desire, subject to the following minimum annual amounts:

Payroll Schedule	Annual Minimum	Minimum Per Pay Period
12-Month	$240	$10.00
Non-12-Month	$240	$12.00

The annual maximum amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you - (a) are married and file a joint return; (b) are married but your spouse maintains a separate residence for the last six months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or (c) are single. If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive cannot exceed the lesser of the earned income (as defined in Code Section 32) of you or your spouse. For purposes of (a) above, your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Qualifying Individuals), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Eligible dependent care expenses must be incurred during the Plan Year and while you are a participant. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective or for any expenses incurred after the close of the Plan Year or after a separation from employment.

If you do not incur an amount of eligible dependent care expenses that match the pre-tax dollars set side and allocated to your account, the allocated amount is forfeited.

Example of Tax Savings with Flexible Spending Accounts (FSA):

	Without FSA	With FSA
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Healthcare FSA	-0-	$50
Pre-Tax Dependent Care FSA	-0-	$60
Taxable Income	$2,500	$2,390
Withholdings @22.65% (Income Tax & FICA)	($566)	($541)
After-Tax Health Care Expenses	($50)	-0-
After-Tax Dependent Care Expenses	($60)	-0-
Net Annual Salary	$1,823	$1,849
Monthly Savings of $26		

www.flexdirect.adp.com

2013 Cost of Coverage

The District pays the cost for your coverage (employee only) in the Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children on a pre-tax basis. All elections for dependent Medical, Dental and Vision coverage are made on a pre-tax basis by way of salary deductions. An employee may choose to opt out of medical coverage if the employee has coverage under another plan and will receive a monthly credit from the District. You pay the cost for your Supplemental Life Insurance on an after-tax basis. These elections are provided under the Premium Conversion Plan maintained by the Board of Education and are governed by Internal Revenue Code Section 125.

2013 Employee Benefits Plan Year

	Monthly Premium	12-Month Employee 24 Pay Period Deductions	10, 10.5, 11-Month Employee 20 Pay Period Deductions
UnitedHealthCare Choice Plus Base Plan			
Employee Only	**$622.24 (Paid by SLPS)**	**$311.12 (Paid by SLPS)**	**$373.34 (Paid by SLPS)**
Spouse	$528.34	$264.17	$317.20
Child(ren)	$306.50	$153.25	$183.90
Spouse & Child(ren)	$707.47	$353.74	$424.28
UnitedHealthCare Choice Plus Buy-up Plan*			
Paid by SLPS (Same as Base)	**$622.24 (Paid by SLPS)**	**$311.12 (Paid by SLPS)**	**$373.34 (Paid by SLPS)**
Employee Only	$57.13	$28.57	$34.28
Spouse	$614.71	$307.36	$368.83
Child(ren)	$376.25	$188.13	$225.75
Spouse & Child(ren)	$807.12	$403.56	$484.27
Delta Dental			
Employee Only	$24.69 (Paid by SLPS)	$12.35 (Paid by SLPS)	$14.81 (Paid by SLPS)
Spouse	$25.91	$12.96	$15.55
Child(ren)	$38.19	$19.10	$22.91
Spouse & Child(ren)	$60.23	$30.12	$36.14
Vision Benefits of America			
Employee Only	$1.53 (Paid by SLPS)	$0.77 (Paid by SLPS)	$0.92 (Paid by SLPS)
Employee + 1	$2.33	$1.17	$1.40
Employee + 2 or more	$4.00	$2.00	$2.40

*** District will pay the same amount toward the Buy-up Plan as they pay for the Base Plan. Employee will pay the difference between the Base and Buy-up plan amount.**

2013 Cost of Coverage

	Monthly Premium	12-Month Employee 24 Pay Period Deductions	10,10.5, 11-Month Employee 20 Pay Period Deductions
CIGNA Insurance (BASIC and AD&D)			
$40,000 Basic Life $40,000 AD&D	($6.00) Paid by SLPS ($.60) Paid by SLPS	($3.00) Paid by SLPS ($.30) Paid by SLPS	($3.60) Paid by SLPS ($.36) Paid by SLPS
CIGNA Supplemental Life EMPLOYEE			
$5,000 $10,000 $20,000 $50,000 $75,000 $100,000 $125,000 $150,000 $200,000	$1.04 $2.08 $4.16 $10.40 $15.60 $20.80 $26.00 $31.20 $41.60	$0.52 $1.04 $2.08 $5.20 $7.80 $10.40 $13.00 $15.60 $20.80	$0.62 $1.25 $2.50 $6.24 $9.36 $12.48 $15.60 $18.72 $24.96
CIGNA Supplemental Life SPOUSE			
$10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000 $80,000 $90,000 $100,000	$2.08 $4.16 $6.24 $8.32 $10.40 $12.48 $14.56 $16.64 $18.72 $20.80	$1.04 $2.08 $3.12 $4.16 $5.20 $6.24 $7.28 $8.32 $9.36 $10.40	$1.25 $2.50 $3.74 $4.99 $6.24 $7.49 $8.74 $9.98 $11.23 $12.48
CIGNA Supplemental Life DEPENDENT CHILD			
$5,000 $7,500 $10,000	$0.75 $1.13 $1.50	$0.38 $0.57 $0.75	$0.45 $0.68 $0.90

Employee Notices

Notice: Medicare Part D Certificate of Creditable Coverage

Important Notice from the Board of Education of the City of St. Louis About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The Board of Education of the City of St. Louis has determined that the prescription drug coverage offered by Wellmark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Wellmark coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current coverage offered by Board of Education of The City of St. Louis, be aware that you and your dependents may be able to get this coverage back, as long as you are an eligible active full time employee.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with The Board of Education of the City of St. Louis and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information: Human Resources Reception at 314-231-3720 for assistance with Medicare Prescription Drug Coverage information ONLY.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Board of Education of The City of St. Louis changes. You also may request a copy of this notice at any time.

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

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

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

Employee Notices

continued from page 36...

For more information about Medicare prescription drug coverage:

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

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

Date: 07/11/2012
Name of Entity/Sender: Board of Education of The City of St. Louis
Contact-Position/Office: Human Resources Reception for Medicare Prescription Drug Coverage ONLY
Address: 801 North 11th Street, St. Louis, MO 63101
Phone Number: (314) 231-3720

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice: HIPAA Special Enrollment Rights

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact the Benefits Call Center at 1-866-345-7577.

Notice: Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

See the next two pages for more CHIP information.

Employee Notices

CHIP continued...

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	LOUISIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
ARIZONA – CHIP	MAINE – Medicaid
Website: http://www.azahcccs.gov/applicants/ Phone (outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741
COLORADO – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In State): 1-800-866-3513 Medicaid Phone (Out of State): 1-800-221-3943	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
FLORIDA – Medicaid	MINNESOTA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629
GEORGIA – Medicaid	MISSOURI – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa/ Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf Phone: 800-792-4884	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

St. Louis Public Schools Benefits Overview

CHIP continued...

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	TEXAS – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Telephone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/equalitycare Telephone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Contact Information

Benefits Call Center
1-866-345-7577
https://portal.adp.com

MEDICAL
UnitedHealthcare
1-800-741-8786
www.myuhc.com

PRESCRIPTION DRUGS
Express Scripts
1-877-850-3348
www.express-scripts.com

DENTAL
Delta Dental
1-800-335-8266
www.deltadentalmo.com

VISION
Vision Benefits of America
1-800-432-4966
www.visionbenefits.com

LIFE INSURANCE
Cigna
1-800-732-1603

FLEXIBLE SPENDING ACCOUNTS
www.flexdirect.adp.com

Employees can make changes online at **https://portal.adp.com** by selecting the link "Enroll in 2013 Benefits."
Employees may also contact the Benefits Call Center at 1-866-345-SLPS (7577).

Customer Service Representatives are available on a year-round basis, Mon - Fri, 7 a.m. - 7 p.m. CST.