2021

Benefits Enrollment Guide

Active Employees

St. Louis Park Public Schools

Achieving success, one student at a time!







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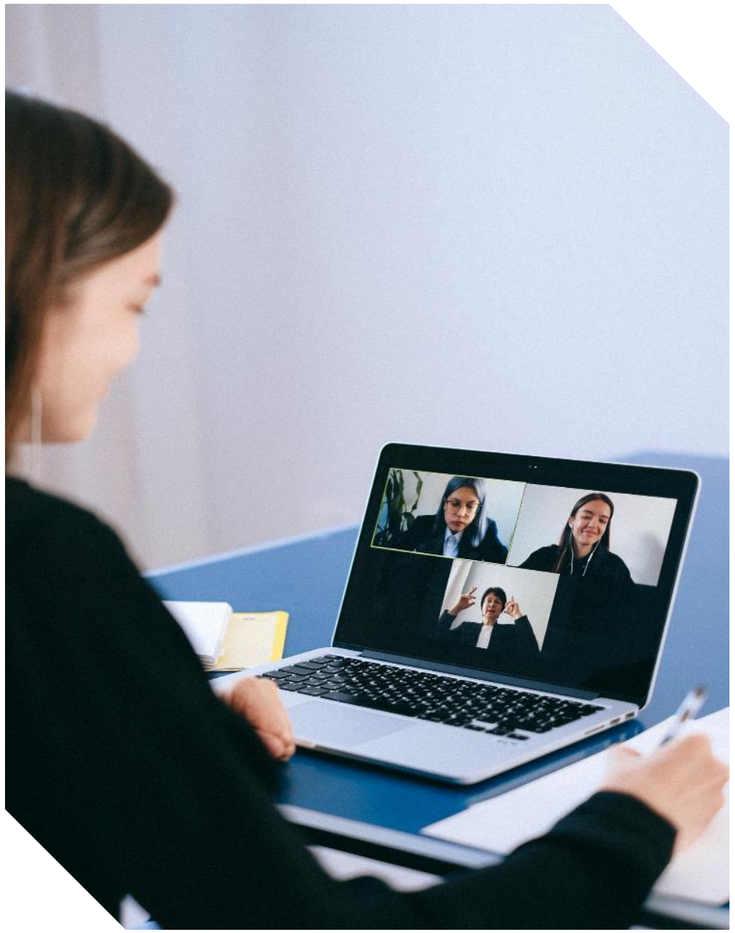

The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

Presented by:

ONEDIGITAL

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Log on to Skyward Open Enrollment Portal.
    - https://skyward.iscorp.com/scripts/wsisa.dll/WService=wsfinstlouisparkmn/seplog01.w%22
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Children age 26 or older
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a “change in status.”

BENEFIT OVERVIEW & HR CONTACT INFORMATION

St. Louis Park Public Schools offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective July 1, 2021:

- Medical benefit plans with PreferredOne
- *NEW* Amplify – see page 6 for details
- Dental benefit plan with Delta Dental of MN
- Basic and Voluntary Life / AD&D, Voluntary Short Term Disability and Long Term Disability benefit plans with The Standard
- VEBA/Flexible Spending Account Administration moving to Further
- COBRA Administration moving to Benefit Extras

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

HR at St. Louis Park Public Schools:
952-928-6000

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MEDICAL PLANS

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

Carrier Name	PreferredOne			
Name of Plan	**Plan A - Copay**		**Plan B - VEBA**	
Type of Plan	**PPO**		**PPO**	
Office Visits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Primary	Primary: $20 Copay	Deductible then 20%	Deductible then 20%	Deductible then 20%
Specialist	$20 Copay	Deductible then 20%	Deductible then 20%	Deductible then 20%
Pharmacy				
Annual Rx Deductible	$750/$1,000	Covered at out of network benefit level. Please see plan design.	$750/$1,000	Covered at out of network benefit level. Please see plan design.
Retail Standard	25%/NonFormulary not covered		25%/NonFormulary not covered	
Retail Specialty	20%		20%	
Mail Order (90 days - Standard)	$11 minimum, $40 maximum		$11 minimum, $40 maximum	
Common Services				
In-Patient Facility	20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Out-Patient Facility	20%	Deductible then 20%	Deductible then 20%	Deductible then 20%
Urgent Care	$20 Copay	Deductible then 20%	Deductible then 20%	Deductible then 20%
Emergency Room	$100 Copay		Deductible then 20%	
Annual Deductible				
Individual	$0	$150	$1,000	$1,000
Family	$0	$300	$2,000	$2,000
Coinsurance	20%	20%	20%	20%
Annual Out of Pocket	Includes Deductible		Includes Deductible	
Individual	$1,250	$1,250	$2,250	$2,250
Family	$2,500	$2,500	$3,500	$3,500
Maximum Benefits	Unlimited - LTM		Unlimited - LTM	

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

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AMPLIFY

LOWER YOUR **HEALTHCARE** COSTS

AMPLIFY by SolarteHealth links qualified employers and their employees with a nationwide network of progressive providers and physicians who are changing the industry with high quality healthcare services. This works together with your existing Plan A or Plan B medical plan.

Common AMPLIFY Services

- Hernia Procedures
- MRIs
- X-Rays
- ACL/MCL Tears
- Hysterectomy
- Knee & Hip Replacements
- Spinal Fusions
- Colonoscopy
- Mental Health
- Primary Care

AMPLIFY

1. Enroll in Plan A or Plan B Medical Insurance.
2. Call your Amplify Patient Advocate when your physician prescribes services or procedures. 1-800-890-4017.
3. Your patient advocate will guide you through the process of scheduling your procedure and any other necessary accommodations with eligible Amplify providers.
4. Receive high quality care **with NO cost to you!** Amplify does not require additional out of pocket or copay for eligible services.

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Employee Perk with District Medical Insurance

Use your Healthy Savings card or app today!

Employees receive 25% off fresh produce, up to $5 in savings each week plus discounts on major brands:

200+ participating brands → $50-100 in member value each week → Pre-qualified as healthy → Stackable with coupons

STEP ONE
Register your card and download the mobile app.

STEP TWO
Save automatically on healthy foods.

STEP THREE
Live healthier.

Healthy Savings is an extra benefit for employees with the District Medical Insurance

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FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

Please check with your HR representative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION (VEBA)

What is a VEBA?

VEBA stands for Voluntary Employees' Beneficiary Association. It is a trust that is exempt from tax under the IRS code 501 (c) (9). The funds in a VEBA are used to reimburse participants for health care expenses.
Health care expenses that are eligible for reimbursement are governed by Section 213(d) of the IRS Code.

ST. LOUIS PARK PUBLIC SCHOOLS VEBA

The VEBA plan option renews each July 1st.

For those employees that elect Plan B - $1,000 Deductible Medical Plan (Plan B), St. Louis Park Public Schools will contribute $1000 annually into the VEBA account. Please refer to your contract for more information. VEBA contributions are made only for active employees. An employee entering the plan after July 1st will receive a pro-rated VEBA contribution.

Any funds not used in the current plan year will roll over into the next plan year.

The VEBA plan is not a replacement for the Flexible Spending Account. Both these plans can be used together.

If you are currently enrolled or will be enrolling in the $1,000 Deductible Medical Plan (Plan B) you are automatically enrolled in the VEBA plan.

***NEW* Further will Administer the VEBA starting 7/1/2021.**

1-855-363-2583 www.hellofurther.com

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DENTAL PLANS

For this plan year, you can choose from the following dental options. Refer to the carrier benefits summaries for the exact benefit level associated with your plan choice.

Carrier Name	Delta Dental of MN			
Name of Plan	Plan A – Delta Dental PPO	Plan B – Delta Dental PPO/Premier		
Type of Plan	PPO	PPO/Premier		
Class	**PPO**	**PPO**	**Premier**	**Out of Network**
Preventive	0%	0%	0%	0%
Basic Restorative	0%	20%	20%	20%
Major Services	40%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Plan Details				
Deductible applies to Preventive	NA	No	No	No
Endodontics/Periodontics: Basic or Major	Basic	Basic	Basic	Basic
Orthodontics (Adult/Children)	Children	Children	Children	Children
Waiting Periods Applied	NA	NA	NA	NA
Deductible				
Person - Plan Year	$0	$25	$25	$25
Family - Plan Year	$0	$75	$75	$75
Plan Maximums				
Plan Year Max	Unlimited	$1,000	$1,000	$1,000
Ortho Lifetime Max	$1,500	$1,000	$1,000	$1,000

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LIFE AND AD&D INSURANCE PLANS

Basic Life

Carrier Name	The Standard
Life Benefit	Based on Group's Contract
AD&D Benefit	Based on Group's Contract
Guaranteed Issue Amount	Based on Group's Contract
Conversion Privilege	Yes
Waiver of Premium	Yes

Voluntary Life

Carrier Name	The Standard
Employee Life and AD&D Benefit	Increments of $10,000 to $500,000 Guaranteed Issue: $100,000
Dependent Life and AD&D Benefit	Spouse: Increments of $5,000 to $250,000 to to exceed 100% of employee's election. Guaranteed Issue: $50,000 Child: $5,000 or $10,000
Conversion Privilege	Yes
Waiver of Premium	Yes

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DISABILITY INSURANCE

Voluntary Short Term Disability

Carrier Name	The Standard
Benefit	60%
Maximum Weekly Benefit	$1,250
Waiting Period-Accident	7 Days
Waiting Period-Sickness	7 Days
Duration of Benefits	90 Days

Long Term Disability Provided by District

Carrier Name	
Benefit	66 2/3%
Maximum Monthly Benefit	$7,500
Who Pays Premium?	District pays on a pre-tax basis. Benefit is taxable.
Elimination Period	90 Days
Own Occupation	24 months
EAP is available for those enrolled on the Long Term Disability: Website: http://www.Workhealthlife.com/Standard3 Phone: 1-888-293-6948	

Did you know?

41% of people with arthritis are forced to limit their physical activity, making it the leading cause of disability in the US.

- Illinois Department of Public Health. “Arthritis and Disability.” 2007. Web Accessed November 10, 2014.

The rates and benefit plan information shown in this guide are illustrative only. To the extent the rates or the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

St. Louis Park Public Schools offers two separate EAP services at no cost to employees or their families. No referrals are needed to see an EAP counselor, and you never have to worry about finding a provider who is in your network. And unlike insurance-covered care, you never have a co-pay. In addition, all household family members are covered regardless if they are covered by other benefits.

The call center is open 24 hours a day, 7 days a week. All operators have clinical backgrounds and at minimum a bachelor's degree in the field. You can also talk to a licensed counselor at any time. Instead of waiting weeks to be seen by a counselor, you can contact one anytime.

We offer short-term counseling to help people work through any problems they may be having. Some counseling sessions are done over the phone, while in other instances the employee visits the counselor.

Vital Worklife: Call 800-383-1908 or visit www.VITALWorkLife.com
The Standard: Call 1-888-293-6948 or visit www.workhealthlife.com/Standard3

- Stress Management
- Divorce/Marital Problems
- Grief
- Feeling Unmotivated
- Feeling Depressed
- Family Issues
- Feeling Stuck
- Drug and Alcohol Issues

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

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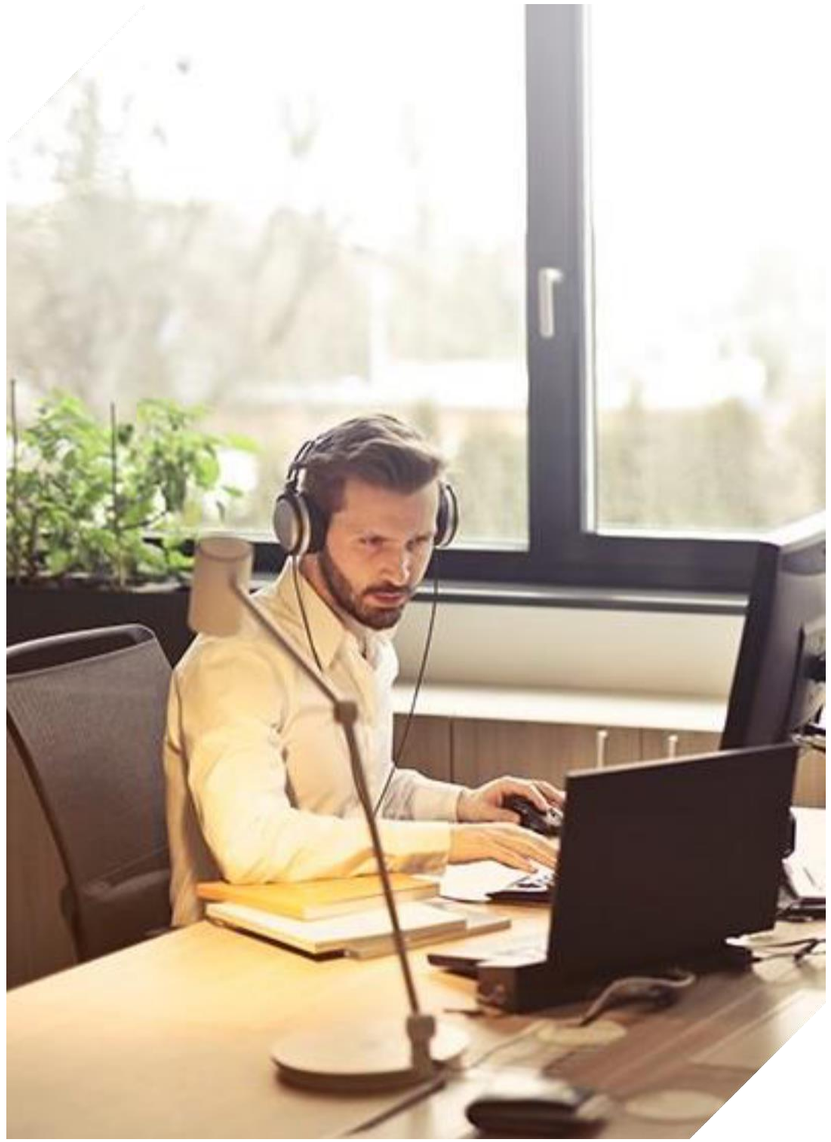
TELEMEDICINE



What is Telemedicine?

- Telemedicine uses technology to facilitate communication, between a doctor and patient who are not in the same physical location for medical evaluation, diagnosis and treatment.
- Speak to a real live doctor 24/7/365.
- All doctors are US Board Certified, licensed to practice medicine and write prescriptions in the state the caller is located in.
- Experienced doctors are here to help.
- 100% HIPAA Compliant.
- Designed for non-emergency care; 71 % of all medical visits today are non-emergency.

Benefits

✓ **Remote Access**
✓ **Specialist Availability**
✓ **Cost Savings**
✓ **Convenient Care**

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MEDICAL AND DENTAL PREMIUMS AND CONTRIBUTION INFORMATION

St. Louis Park Public Schools contributes to the cost of the medical and dental plans for you and your family. To determine what you will pay per month look at your employee agreement for Health and Dental Insurance. The subtract the amount the District pays from the total monthly premiums below. For example, if you are choosing Medical Plan B Employee only and your contract says the District pays $570 per month, then the cost to you is $716-$570 = $146 / month.

Coverage Tier	Total Monthly Premiums
Medical Plan A - Copay	
Employee	$817.00
Employee + 1	$1,736.00
Family	$2,417.00
Medical Plan B - VEBA	
Employee	$716.00
Employee + 1	$1,518.00
Family	$2,114.00
Dental Plan A	
Employee Only	$54.27
Family	$120.71
Dental Plan B	
Employee Only	$47.19
Family	$104.97

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EMPLOYEE VOLUNTARY LIFE/AD&D and VOLUNTRAY SHORT TERM DISABILITY RATES

Age	Voluntary Life Rates/$1,000 of Benefit	Voluntary Short Term Disability /$10 of Weekly Benefit
0-29	$0.060	$0.356
30-34	$0.080	$0.374
35-39	$0.100	$0.207
40-44	$0.160	$0.125
45-49	$0.280	$0.126
50-54	$0.460	$0.133
55-59	$0.730	$0.173
60-64	$1.140	$0.218
65-69	$2.060	$0.218
70-74	$3.710	$0.218
75-99	$3.710	$0.218
Voluntary AD&D	$0.015	

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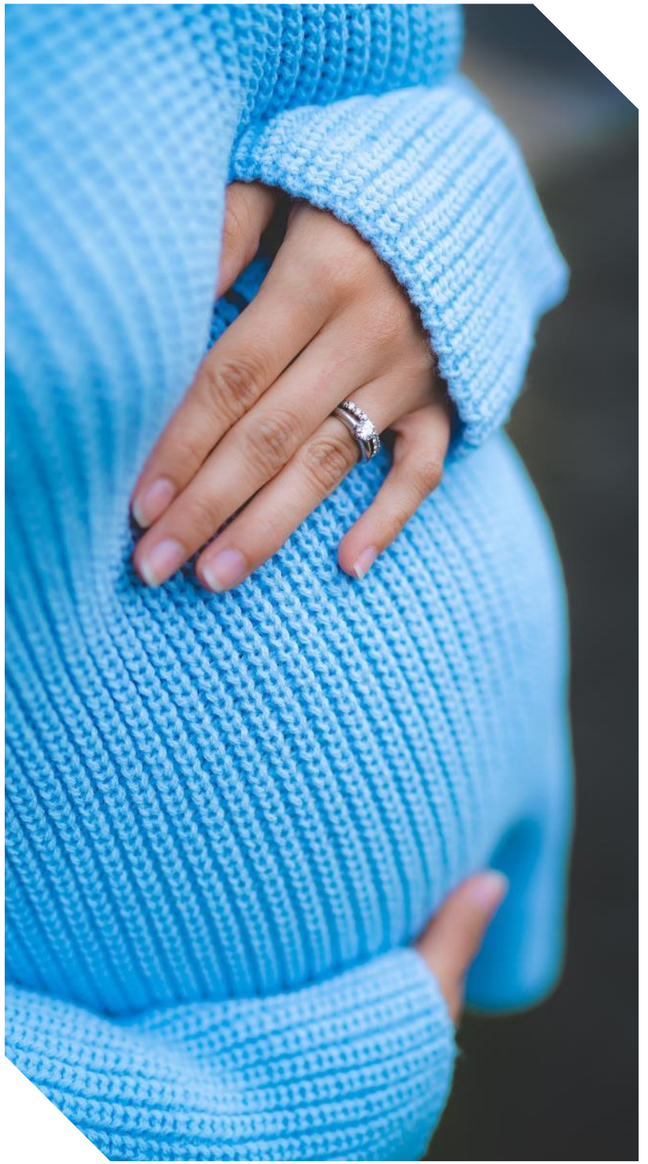
REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

- Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

- In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.



REQUIRED CHIP NOTICE

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

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

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

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

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

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

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REQUIRED CHIP NOTICE (CONT)

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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REQUIRED CHIP NOTICE (CONT)

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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OMB Control Number 1210-0137 (expires 1/31/2023)

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HIPAA Notice

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

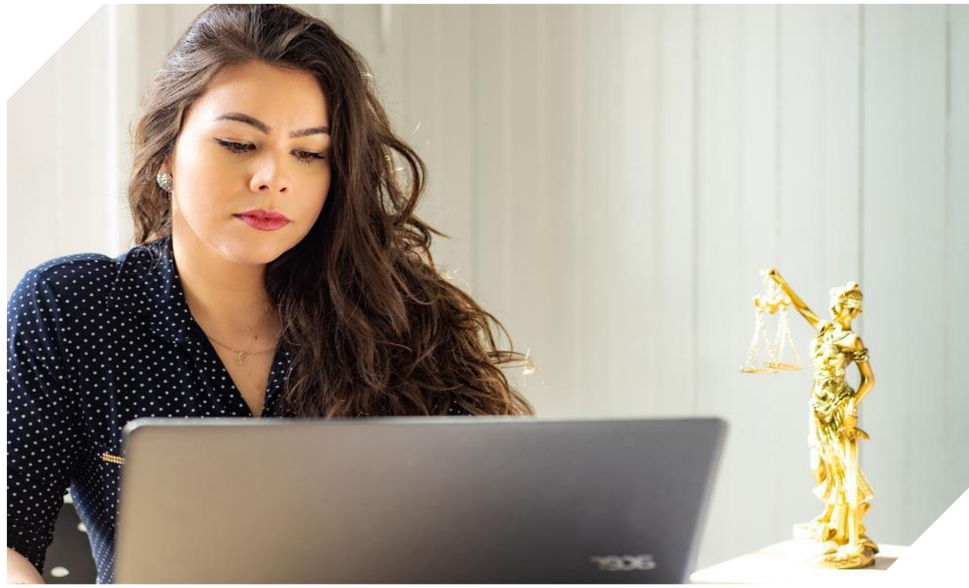
Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/

Model Special Enrollment Notice

If you are declining 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 the appropriate time period that applies under the plan after you 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 the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

For additional information on your employer's privacy policy, please contact your HR department.



CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Glossary of Health Coverage and Medical Terms

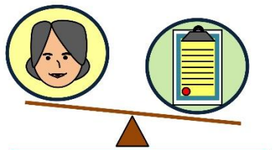
- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance


(See page 6 for a detailed example.)

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible


(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services
Health care services that your plan doesn't pay for or cover.

Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care
Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

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Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

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

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

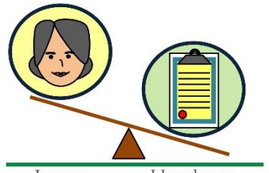
Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit


(See page 6 for a detailed example.)

The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

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Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

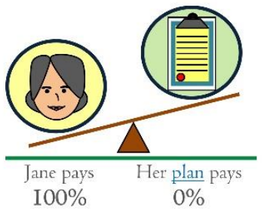
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

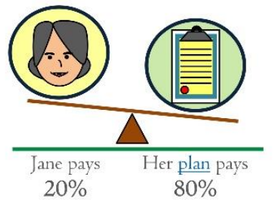
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



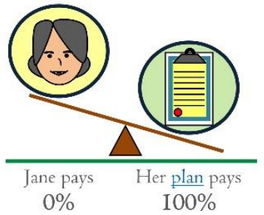
Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs



Jane reaches her $1,500 deductible, coinsurance begins
Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

more costs



Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125

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CARRIERS, VENDORS & CONTACTS

Program	Vendor	Contact Information
Medical/Rx	PreferredOne Amplify	763-847-4477 or 1-800-997-1750 www.preferredone.com 612-849-2050 www.Solartehealth.com/amplify
Dental	Delta Dental of Minnesota	651-406-5916 or 1-800-553-9536 www.deltadentalmn.org
Basic Life/AD&D, Voluntary Life/AD&D, Voluntary Short Term Disability and Long Term Disability	The Standard	Life Insurance: 1-800-628-8600 Long Term Disability Phone Number: 1-800-368-1135 www.Standard.com
VEBA/Flexible Spending Accounts	Further	1-855-363-2583 www.hellofurther.com
COBRA Administration	Benefit Extras	952-435-6858 www.benefitextras.com
Employee Assistance Program (EAP)	Standard Vital Worklife	1-800-293-6948 www.Workhealthlife.com/Standard3 1-800-383-1908 www.vitalworklife.com
Healthy Savings Discount Program	Healthy Savings	www.Myhealthysavings.com
Fitness Program	Wellbeats	1-866-736-6640 www.wellbeats.com

Additional Benefit Information

St. Louis Park Public Schools

Achieving success, one student at a time!

ONEDIGITAL HEALTH AND BENEFITS

2021

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