FOCUS ON BENEFITS

2022 Plan Year

Elmbrook Schools
become what's next

This piece is not a contract, but a summary of your benefits. Please refer to your contract (Summary Plan Description or Certificate of Coverage(s)) for more detailed information. In case of conflict, your contract will prevail for all claim adjudication.

Revised: September 2021

FOCUS ON BENEFITS 2022

Elmbrook School District

What's new?

Benefit elections you make or maintain during open enrollment will become effective January 1 of each year. For new hires, benefit elections you make are effective on your first day.

This brochure includes the benefits and enrollment material offered at Elmbrook School District for 2022. We encourage you to take the time to read through and explore your benefits. At Elmbrook School District, we value our employees and are committed to providing a comprehensive and competitive benefits package.

Certain benefits you elect require an employee contribution. In some cases, those contributions will be deducted from your check on a pre-tax basis; in other cases, the deduction will be made after-tax to avoid certain tax consequences to you and the company. For taxability of benefit elections, please contact a member of the "Total Employee Rewards" Team.

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FOCUS ON BENEFITS 2022

Elmbrook School District

HEALTH PLAN SUMMARY

Effective January 1, 2022, we will continue to offer a health plan through UMR for all benefit-eligible employees.

About the Health Plan: Preventive care is covered at 100% and no deductible applies. For other services, this plan requires a deductible before eligible services are paid at 85% coinsurance (coins).

Features	Tier 1 Premium Designation	Tier 2 UHC Choice Plus Network	Tier 3 Out-of-Network
Deductible *per calendar year*	$ 2,000/$4,000	$ 2,000/$4,000	$4,000/$8,000
Out-of-Pocket Max *per calendar year*	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000
Coinsurance *% paid after deductible is met up to OOP Max*	100%	85%	65%
Office Visits-Primary Care *Office visits, Urgent Care Clinic, Retail Health Clinics, Chiropractic Manipulation*	Ded, 100% Coins	Ded, 85% Coins	Ded, 65% Coins
Routine/ Preventive Services *Physical Exam, Well child, Immunizations, Certain Prenatal Services, Screenings*	100%	100%	Ded, 65% Coins
Emergency Room	No Benefit see Tier 2	Ded, 85% Coins	In-Network Ded, 85% Coins
Inpatient Hospital	No Benefit see Tier 2	Ded, 85% Coins	Ded, 65% Coins
Outpatient Hospital	No Benefit see Tier 2	Ded, 85% Coins	Ded, 65% Coins
Prescription Drugs *Preventive and OTC* *Generic* *Preferred Brand* *Non-Preferred Brand Tier* *Retail 30 days (90 days-CVS, Target)*	0-% Ded, 90% coins Ded, 90% coins Ded, 85% coins	Ded, 85% coins	Ded, 85% Coins
Mail Order Prescription Drugs *Maintenance meds–mandatory mail CVS-Caremark Mail Order/ Retail Pharmacy 90 days*	Ded,90% Coins	Ded, 85% Coins	Ded, 85% Coins
Lifetime Maximum	Unlimited	Unlimited	Unlimited

The district will continue to pay a portion of your premiums. Premiums are shown per month effective January 1, 2022 and remain the same for the 2022 plan year:

Monthly Premium	Employee Premiums		Employer Premiums	
	Single	Family	Single	Family
Active Employees (40hrs/week)	$47.30	$113.98	$645.22	$1,554.68
Active Employees (30-39 hrs/week)	$47.30	$227.96	$645.22	$1,440.70

Please review your benefit plan summary document for more detailed coverage information.

UMR

A UnitedHealthcare Company

Our plan uses the **UMR's UnitedHealthcare Choice Plus network** for participating providers.

BALANCE BILLING

The amount that the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Always use an in-network provider for the highest coverage of services.

SUMMARY OF BENEFITS COVERAGE

Refer to your Summary Plan Description and Summary of Benefit Coverage (SBC) and more located on your "Total Employees Rewards" site at elmbrookschools.org/rewards for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

QUESTIONS?

Call the phone number on the back of your ID card or visit www.umr.com.

Contact Optum Consumer Services at Contact Optum Bank- at 844-973-3925 or healthaccountservicing@optum.com (24 hours a day) or, on the internet, at optumfinancial.com.

Contact a DirectPath Care Navigator at advocate@directpathhealth.com or call 1-866-253-2273 (Monday - Friday, 7am - 8pm CST and Saturday, 8am - 1pm CST).

ELMBROOK FAMILY WELLNESS CENTER CLINIC

$20 PER CARE/TREATMENT VISIT

$0 PREVENTIVE EXAM, LABS, IMMUNIZATIONS

The Clinic provides comprehensive management of chronic conditions and general care for employees, spouses, dependent (age 2+) and retirees covered by the Elmbrook Health Plan.

The staff at the Elmbrook Schools Family Wellness Center is ready to help you stay healthy, lower risk factors and improve your quality of life.

Medications available with Wellness Center staff via written prescription through on-site dispensary, retail pharmacy or CVS/Caremark mail order.

Acute Care – getting back to healthy
Treating illnesses, minor injuries, and skin conditions.
Cold/flu
Conjunctivitis
Cuts
Headache/migraine
Ear Infections
Fever
Muscle and joint pains
Nausea/vomiting
Rashes
Sinus infections
Sore and strep throat
AND MORE!

Preventive Care – staying healthy
Administering vaccines, health education, and wellness services.
Pediatric Care
Wellness Screenings
Wellness Coaching
Annual Physicals
Well-Woman Physicals
Vaccinations
Weight Loss
Smoking Cessation
AND MORE!

Disease Management – maintaining your health
Developing treatment plans and follow-up for chronic conditions.
Allergies
Asthma
EAP Referrals
Diabetes
Emphysema
High blood pressure
High cholesterol
Thyroid conditions
Weight management
AND MORE!

CLINIC HOURS:

Monday: 7:00 a.m.- 5:00 p.m.
Tuesday: 9:00 a.m.- 7:00 p.m.
Wednesday: 9:00 a.m.- 7:00 p.m.
Friday: 6:00 a.m. – 11:00 a.m.

SCHEDULE AN APPOINTMENT:

Direct Line [Office Hours]: (262) 214-1101
Scheduling: (866) 959-9355

www.elmbrookschools.org/wellnesscenter

ADDRESS:

17000 W. North Avenue
Suite 100E
Brookfield, WI 53005

MEET YOUR CENTER STAFF:

Kalmette (Kalee) Cambray
DNP, APNP, AGACNP-BC, FNP-C
Doctorate in Nurse Practice

- Experienced in primary care, internal medicine, pediatrics, urgent care & emergency medicine
- Licensed in WI to diagnose, treat, prescribe & dispense medications

Leslie Pierce, MPSPAS, PA-C
Physician's Assistant

- Experienced in family medicine and treating acute and chronic conditions
- Licensed to diagnose, treat, prescribe & dispense

Alise Brown
Wellness Coach

- Diabetes
- Weight management
- Hypertension
- Hyperlipidemia
- Meal planning & preparation
- Exercise planning & preparation
- Stress management support
- Healthy lifestyle support

Catherine Schindler
Medical Office Assistant

Karen Befi
Center Receptionist

HEALTH SAVINGS ACCOUNT

- Contributions are tax-deductible and interest earnings are tax-free.
- Your HSA contributions accumulate and roll over each year.
- **Elmbrook's Annual Contribution toward your HSA: $1,000 single/ $2,000 family**
- Account funds remain until spent. There is no "use-it-or-lose-it" rule. You own your HSA account.
- Account funds should only be used for qualified medical, prescription, dental or vision out-of-pocket expenses.
- Non-qualified expenses are subject to a 20% penalty and charged as taxable income.
- Withdrawals are tax-free when used for eligible expenses.
- Maximum contributions are $3,650/single or $7,300/family for 2022 (employer and employee contributions combined).
- If you fund a new HSA with the max contributions, you will need to be enrolled in the HSA for the entire plan year, or penalties apply.
- Catch-up contributions may be made annually for those 55 and older, up to $1,000.
- HSA accounts are not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited purpose medical FSA (vision & dental only).
- Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage, such as a spouse's non-qualified High Deductible Health Plan. Please notify HR if you enroll in Medicare or other disqualifying coverage to terminate HSA contributions and avoid adverse tax consequences. If you are eligible for (but not enrolled in) Medicare please contact HR before continuing any HSA contributions.
- Your HSA administrator is Optum Bank:
  - optumfinancial.com
  - Contact Optum Bank- at 844-973-3925 or healthaccountservicing@optum.com

TOP REASONS TO HAVE AN HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep. (Employer-paid account fees cease upon termination of health plan.)

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests, and prescription medications, both deductible and coinsurance.

Reduced Insurance Premiums — The cost of coverage under a qualified HDHP is typically lower than the other plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax-deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, withdrawals however, are subject to tax.)

Safety Net — An HSA has no "use-it-or-lose-it" restrictions, so balances can be built up to use for major medical events.

Coverage for the "Extras" — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over a certain amount may be invested. See your Optum HSA rules.

Empowerment — Take control of your health care decisions, including which providers you use, to ensure your health care dollars are spent wisely.

How do I activate and use my Optum HSA account?

Activate the bank account online at optumfinancial.com using your name as it appears in the Skyward payroll system and Social Security number or employee ID number (that you can obtain from the Skyward Employee Portal, or staff in your Payroll, Benefits or HR Departments or your school front office). Once you have activated your online bank account with a username and password, you can check balances, set-up a personal bank account from which to transfer monies to and from covering claims and deposits not deducted from payroll. We suggest including an e-mail address in the profile to receive important tax-year notifications and assist with username or password recovery.

There is only one bank available for the HSA with the District. This is the best way to help everyone with the set-up and access to a bank account with immediate availability to deposit employer contributions.

Are there any bank fees assessed to my Optum HSA Account?

No, there will be no bank fees assessed to your account while you are active in Elmbrook's HDHP medical plan. The District covers the administrative costs for insureds covered within the medical plan. Should you require a replacement debit card, you will need to request from Optum and inquire if there is a fee for the service.

How do I use my debit card?

Once you have activated your Optum debit card, you may use it up to the amount available in your HSA account at a pharmacy, medical, dental or vision provider to pay a bill once processed through the insurance carrier(s). Note that only card readers that accept HSA debit cards will allow the transaction. No PIN is required (be sure to select "credit" when swiping the debit card). You may also pay a bill by including the debit card number on a billing statement forwarding to the provider. Allow UMR, Delta Dental and EyeMed to process claims and apply any network discounts before paying. Keep all receipts with your income tax files should the IRS ever require proof of use for HSA funds.

What are the employer contributions and when are they available?

The annual employer contribution for single coverage is $1,000 and for family $2,000. Contributions will be deposited within three banking days from the payroll dates based on the schedule below and is pro-rated for mid-year hires/change in enrollment.

Contribution Month	Single	Family
February - 2nd payroll	$600	$1,200
September – 2nd payroll	$400	$ 800

Deposits may be only made into a HSA bank account while the employee is insured under a qualified High Deductible Health Plan (HDHP) such as Elmbrook's and not covered under Medicare. Money not spent within a plan year will remain in the bank account balance and may be used on qualified medical, prescriptions, dental and vision expenses in the future regardless of the current medical plan enrolled. Current law allows Medicare supplement premium payments to be paid with HSA account. HSA funds may be left to a beneficiary (as designed by the IRS) for use in covering their out-of-pocket medical, prescription, dental and vision expenses as well.

How do I file an HSA Claim?

You are able to use your Optum Bank HSA debit card to pay on the spot at a provider or pharmacy or pay a bill that you receive from a doctor's office or other health care facility. If you paid for a qualified expense out-of-pocket, you can login to optumfinancial.com and request an ACH or check disbursement.

How do I use the HSA to pay for medical care?

It is rather simple. Here are the steps:

1. You and/or the company puts money into the HSA.
2. You or a dependent receives medical services.
3. A bill for medical services is submitted as a claim to UMR.
4. You receive an Explanation of Benefits for the service, which will reflect the amount due to the provider.
5. At this time you can choose to:
    - Use your HSA funds to pay the provider directly for the amount due
    - Pay the provider with personal funds and request reimbursement
    - Use your funds and save your HSA dollars for future medical expenses
6. Process repeats until deductible and out-of-pocket maximums are met, after which benefits are paid for the remaining plan year.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to www.umr.com to search for Premium Designated providers and clinics that offer the medical services you need at the best cost.

DirectPath Care Navigator is also available to help you find high value provider options. Call DirectPath at 1-866-253-2273 or email advocate@directpathhealth.com, (Monday - Friday, 7am - 8pm CST and Saturday, 8am - 1pm CST).

Can I withdraw money from an HSA for non-medical expenses?

Yes, but if you withdraw funds for non-medical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.

Can I have a Medical Flexible Savings Account (FSA) along with an HSA?

You can enroll in a Limited Purpose – FSA for **vision and dental expenses only** up to $2,850. Examples of when you might want both HSA and FSA include a large upcoming dental expense beyond your district coverage and HSA account contributions, planning a laser vision eye surgery or if you want to deposit as much as possible in your HSA account and expect to have dental or vision expenses. Please note, if you have a Limited Purpose FSA, you can only use your HSA for medical and prescription expenses.

Remember: The limited purpose FSA does NOT allow access to unclaimed dollars beyond December 31st in that plan year - NO mid-year changes are allowed unless you have a qualifying event defined by the IRS.

BE A SMART HEALTHCARE CONSUMER!

You have different care options to choose. Gaining a better understanding of your options now can help you save both time and money when you need to seek care. Options for treatment include:

Elmbrook Schools Family Wellness Center: Located at 17000 W. North Avenue, Suite 100E in Brookfield, our Wellness Clinic provides comprehensive management of chronic conditions and general care for employees, spouses, dependent (age 2+) and retirees covered by Elmbrook Health Plan. **Cost: $**

Convenience Care, Online Care: Located inside of retail stores or online (Teladoc), visit these for common aliments like strep throat, pink eye, bladder infection, etc. **In-Network Cost: $**

Doctor's Office: Staffed by doctor, PA and nurses, visit this for care of illnesses, injuries, preventive care, etc.
Cost: $$

Urgent Care Clinic: Staffed by doctor, PA and nurses, visit this for care of minor illnesses or injuries that require **immediate** attention.
Cost: $$$

Emergency Room: Located inside of a hospital, visit this for serious illnesses, injuries or life-threatening issues, such as, chest pains, shortness of breath, burns, head injuries, etc.
Cost: $$$$

DENTAL PLAN SUMMARY

About the Dental Plan: This is a comprehensive plan for all dental services and covers preventive care at 100% in-network, with no deductible**.** You may use any dentist for your dental services; however, using an in-network dentist will reduce your out-of-pocket costs.

Features	PPO Dentist	Premier Dentist
Annual Maximum	$2,000	$2,000
Annual Deductible *Does not apply to preventive and diagnostics*	None	None
Diagnostic & Preventive	100%	100%
Basic Restorative Care *Amalgam & Resin Fillings*	100%	100%
Oral Surgery *Simple Extractions*	100%	100%
Endodontic Therapy *Root Canal*	100%	100%
Periodontics *Gum disease*	100%	100%
Major Restoratives *Resins, Crowns*	80%	80%
Prosthetics and Implants	80%	80%
Orthodontic		
Coverage Copayment	50%	50%
Individual Lifetime Maximum	$1,500	$1,500
Dependents eligible to age	25	25
Adult Ortho	Yes	Yes

Dental Plan Premiums: We contribute to your premiums. Rates shown are monthly and are effective January 1, 2022 and remain through the 2022 plan year:

Monthly Premium	Employee Premiums		Employer Premiums	
	Single	Family	Single	Family
Active Employees (40hrs/week)	$6.80	$16.88	$47.20	$117.08
Active Employees (30-39 hrs/week)	$6.80	$33.76	$47.20	$100.20

Please review your plan summary document for more detailed coverage information.

DELTA DENTAL®

We offer the Delta Dental PPO dental plan. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out-of-network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

INFORMATION ON THE GO!

Access your dental account information from your smartphone or mobile device with Dental Delta app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist
- Brush with toothbrush timer

AMPLIFON HEARING HEALTHCARE

As a Delta Dental member, you receive discounts and savings on hearing diagnostic testing, along with the guaranteed lowest pricing on hearing aids. Call 1-888-901-0132 or visit www.amplifonusa.com/deltadentalWI for information.

QUESTIONS?

Call customer service at **800-236-3712** or call the phone number on the back of your ID card or visit **www.deltadentalwi.com.**

VISION PLAN SUMMARY

About the Vision Plan: This is a comprehensive plan for all vision services listed below. You may use any vision provider for your vision services; however, using an in-network provider will reduce your out-of-pocket costs.

Additional discounts

40%OFF
Complete pair of prescription eyeglasses

20%OFF
Non-prescription sunglasses

These discounts are not insured benefits and are for in-network providers only. For vision plans with qualified materials benefit only. Not applicable for exam only vision plans.

Take a sneak peek before enrolling

- You're on the Insight Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982
- For LASIK providers, call 1.800.988.4221

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Any available frame at provider location	$0 copay; 20% off balance over $130 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Progressive - Standard	$80 copay	Up to $50
Progressive - Premium Tier 1	$110 copay	Up to $50
Progressive - Premium Tier 2	$120 copay	Up to $50
Progressive - Premium Tier 3	$135 copay	Up to $50
Progressive - Premium Tier 4	$200 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1	$57 copay	Up to $5
Anti Reflective Coating - Premium Tier 2	$68 copay	Up to $5
Anti Reflective Coating - Premium Tier 3	$85 copay	Up to $5
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Std - Dependent Children	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $91
Contacts - Disposable	$0 copay; plus balance over $130 allowance	Up to $91
Contacts - Medically Necessary	$0 copay; Paid-In-Full	Up to $210
OTHER		
Hearing Care from Amplifon NetworkCare	Discounts on hearing exam and aids; call 1.844.526.5432	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCIES *(Plan allows member to receive either contacts and frame, or frames and lens services)*

Exam	Once every plan year
Frame	Once every other plan year
Lenses	Once every plan year
Contacts	Once every plan year

Vision Plan Premiums: Voluntary plans offer monthly premiums, deducted from pay on a semi-monthly basis, effective January 1, 2022 and remain through the 2022 plan year:

Monthly Premium	Employee Premiums			
	Single	EE + Sp	EE + Ch	Family
Active Employees (40hrs/week)	$4.31	$8.19	$8.62	$12.67
Active Employees (30-39 hrs/week)	$4.31	$8.19	$8.62	$12.67

Please review your plan summary document for more detailed coverage information.

We offer the EyeMed vision plan. Always use an "Insight" in-network provider to obtain the highest level of benefits.

When accessing care out-of-network, there is a maximum reimbursement that is available.

INFORMATION ON THE GO!

Access your vision account information from your smartphone or mobile device with EyeMed app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist

QUESTIONS?

Call customer service at **844-225-3107** or call the phone number on the back of your ID card or visit **www.eyemed.com.**

FLEXIBLE SPENDING ACCOUNTS

What is a Limited Purpose Flexible Spending Account (LPFSA)?

A Limited Purpose Flexible Spending Account is an account you can enroll in when you have an HSA to use on only dental and vision expenses . This allows you to set aside money to pay for eligible dental/vision expenses with tax-free dollars.

You can contribute up to $2,850.

When would I want a Limited Purpose Flexible Spending Account and an HSA?

Some examples of when you might want both HSA and LPFSA would include when you expect a large upcoming dental expense beyond your district coverage and HSA account contributions, planning a laser vision eye surgery or if you want to deposit as much as possible in your HSA account and expect to have dental or vision expenses.

What are eligible Limited Purpose Flexible Spending Account expenses?

- Dental expenses
    - Cleanings, x-rays, fillings caps, crowns, braces, bridges
- Vision expenses
    - Eye exams, glasses, frames, lenses, contact lenses, LASIK

What if I don't use all my LPFSA money?

Expenses need to be incurred during the LPFSA plan year. All unused funds may be subject to the use it or lose it provision. Plan conservatively. **These funds can only be used for dental and vision expenses.**

Remember: Claims for the plan year are due no later than 90 days of plan ending, December 31st.

The FSA does NOT allow access to unclaimed dollars beyond December 31st in future plan year(s).

NO mid-year changes are allowed unless you have a qualifying event defined by the IRS.

DEPENDENT CARE FSA

What is a Dependent Care FSA?

Use this account to cover the cost of dependent care while you work. You may use this for expenses for the care of a child under age 13 or a disabled spouse, child or parent. If you are married, your spouse must be employed or attending classes full-time for you to use the Dependent Care Spending Account. You may contribute up to $5,000 per year per household to this account or $2,500 per year if you are married and file your taxes separately.

What expenses qualify under a Dependent Care FSA?

- Child or adult care center that complies with State and Local regulations (not including nursing homes)
- Sitter inside or outside the home
- Daycare during school vacation, provided it is not primarily for educational purposes
- Nursery school, even if the school provides educational services
- Relative who cares for eligible dependents, as long as that relative is not your dependent and is age 19 or older

IRS Publication 503, Child and Dependent Care Expenses, contains a list of expenses eligible for reimbursement under the FSA — Dependent Care. Go to www.irs.gov for a complete copy of the list.

How do I file a claim?

You are able to use your Optum Bank FSA debit card to pay on the spot at a provider or pharmacy or pay a bill that you receive from a doctor's office or other health care facility. If you paid for a qualified expense out-of-pocket, you can login to **optumfinancial.com** and request an ACH or check disbursement.

HEALTH REIMBURSEMENT ARRANGEMENT

What is a health reimbursement arrangement (HRA)?

HRA's are Consumer Driven Health Plans with employer-funded medical deductible reimbursement arrangements. The employer sets aside a specified amount of pre-tax dollars for employees to pay medical expenses on an annual basis.

Who is offered an HRA as a part of their Health Plan?

Insureds, who themselves (does not include a spouse or dependent) are covered under Medicare or other governmental insurance coverage may not have contributions to a Health Savings Account per IRS rules. With this, insureds are required to notify the employer of their Medical/governmental insurance enrollment and those qualified for and electing District health insurance benefits are offered an HRA as a part of Elmbrook Schools health plan.

Members who had the Health Plan with an HRA, eliminated in 2018, were moved to the plan with a Health Savings Account. Any HRA balance remains available while covered under a District health plan. Under IRS rules, in 2022, once you satisfy $1,400 of your $2,000-Single or $2,800 of your $4,000-Family deductible, you may make claim for medical and prescription expenses from your HRA. Dental and vision expenses may be claimed without being subject to a portion of your deductible.

How much is funded annually?

Elmbrook funds $1,000-Single and $2,000-Family annually for insureds covered with an HRA.

How and when do I receive reimbursements from the HRA?

HRA claims for reimbursement may be completed online, faxed or mailed to Diversified Benefit Services along with copies of all Explanation of Benefit (EOB) statements from UMR/Dental insurer or paid receipts (vision care) showing the amount claimed.

Claims with dates of service through December 31st of the plan year must be submitted within 90 days of the following year (March 31st or March 30th in leap years).

Note: HRA claims, submitted through March for the current year, will not be processed until after the prior year claims are completed and paid. The first reimbursement for the current year begins each April.

(continued on next page)

HEALTH REIMBURSEMENT ARRANGEMENT (con't)

Will funds that I haven't used in one-year rollover to the next year?

If all the annual funding for reimbursement in a plan year is not used, monies will be carried forward for use on claims with service dates in the following year.

If your health plan was eliminated in 2018 and you were moved to the High Deductible Health Plan and qualify for a Health Savings Account (HSA), monies in the HRA remain available while the member is covered under a District health plan. Under IRS rules, in 2022, once you satisfy $1,400 of your $2,000-Single or $2,800 of your $4,000-Family deductible, you may make claim for medical and prescription expenses from your HRA. Dental and vision expenses may be claimed without being subject to a portion of your deductible.

ANCILLARY PLANS

All benefit eligible employees are eligible for life insurance, accidental death & dismemberment (AD&D), voluntary life and AD&D through Reliance Standard and voluntary short-term disability (STD) and long-term disability (LTD) plans provided by National Insurance Services.

LIFE AND AD&D

Benefit eligible employees are covered based on your annualized earnings rounded to the next $1,000, subject to a maximum of $100,000 for the basic life plan. You are also covered at the same amount for the AD&D plan. The original amount of the Life and AD&D benefits will reduce as you age and terminate upon your retirement or termination of employment. Now is a great time to review or update your beneficiary. Reference your Employee Handbook for benefit eligibility. The District pays 100% of the premium for you.

VOLUNTARY LIFE AND AD&D

Benefit eligible employees are able to enroll in Voluntary Life and AD&D for themselves and their dependents. Employee elections are in $5,000 increments between $5,000 and $370,000, not to exceed five times your salary. Spouse elections are in $5,000 increments between $5,000 and $100,000, not to exceed 50% of the employee election. Guaranteed issue for first time eligible employees is the lesser of three times your annual salary or $250,000 for employee coverage and $20,000 for spousal coverage. Any amount over the guaranteed issue requires Evidence of Insurability (answering medical questions). Elections for all qualified children (age 14 days to 26 years old) within a family are in $2,500 increments between $2,500 and $10,000. Notify the HR Department as children should be removed from your plan. The Voluntary Life coverage includes the same amount for the Voluntary Accidental Death & Dismemberment plan. Coverage will terminate at the end of the month in which employment is terminated.

Now is a great time to review or update your beneficiary. Reference your Employee Handbook for benefit eligibility. You pay 100% of the cost of the premium.

Rates are available at the link on the Resource Page.

Questions on Eligibility and Coverage?

Contact Your Human Resources Department

Reliance Standard Life

Customer Service:
https://customercare.rsli.com/

Customer Care Center
800-351-7500
(7 a.m. - 6 p.m CST weekdays)

LONG-TERM DISABILITY

Elmbrook Schools provides benefit eligible employee with Long-Term Disability (LTD) coverage. Benefit eligible employees may receive 70% of earnings up to a maximum monthly benefit of $9,333 in the event of a qualifying disability claim. Benefits may begin after a 60-day elimination or waiting period. LTD benefits are taxable to the member upon receiving the claim payment. Reference your Employee Handbook for benefit eligibility. The District pays 100% of the premium for you.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

You may purchase supplement coverage of up to 66% of your annual salary in the event of a qualifying disability claim. Benefits for a covered illness or injury continue for 60 days, the date you are no longer disabled or until you are eligible to receive benefits under your LTD policy, whichever comes first. Benefits start on the 1st day for a covered disability resulting from an accident and 4th day for disability resulting from an illness. Short-term disability (STD) is offered through Madison National Insurance Company. You pay 100% of the cost of the premium.

VOLUNTARY STDI INSURANCE RATES

Weekly Benefit	Rate per Month
☐ $147.00	$9.70
☐ $175.00	$11.32
☐ $224.00	$14.52
☐ $273.00	$17.78
☐ $301.00	$19.40
☐ $357.00*	$23.18

Weekly Benefit	Rate per Month
☐ $420.00*	$26.96
☐ $462.00*	$29.64
☐ $504.00*	$32.34
☐ $580.00*	$37.17
☐ $667.00*	$42.72
☐ $767.00*	$49.14

Weekly Benefit	Rate per Month
☐ $882.00*	$56.51
☐ $1,014.00*	$64.99
☐ $1,166.00*	$74.74
☐ $1,341.00*	$85.95
☐ $1,500.00*	$98.84
☐ I wish to decline this coverage.	

*To be eligible for these benefit levels, you must provide proof of insurability by answering a health questionnaire and meeting medical requirements.

Complete STDI Application form and return to the HR Benefits Department.

Questions?

- Eligibility/Coverage
- STDI Application

Contact Your Human Resources Department

VOLUNTARY SHORT-TERM DISABILITY BENEFIT LEVELS

If your annual salary is between:	Your choice of the corresponding benefit level or less
$11,465 - $13,648	$147.00
$13,649 - $17,470	$175.00
$17,471 - $21,291	$224.00
$21,292 - $23,475	$273.00
$23,476 - $27,843	$301.00
$27,844 - $32,757	$357.00*
$32,758 - $36,033	$420.00*
$36,034 - $39,309	$462.00*
$39,310 - $45,236	$504.00*
$45,237 - $52,022	$580.00*
$52,023 - $59,822	$667.00*
$59,823 - $68,791	$767.00*
$68,792 - $79,087	$882.00*
$79,088 - $90,942	$1,014.00*
$90,943 - $104,591	$1,166.00*
$104,592 - $116,993	$1,341.00*
$116,994 +	$1,500.00*

Examples:

- Annual salary of $22,000 can apply for a benefit amount of $273 or less.
- Annual salary of $30,000 can apply for a benefit amount of $357 or less.
- Annual salary of $40,000 can apply for a benefit amount of $504 or less.

Madison National Disability

Customer Service:
National Insurance Services
Dawn Pfeiffer
Account Representative
dpfei@nisbenefits.com

p: 262.780.1207
f: 262.814.1207

NEXT STEPS

HEALTH PLAN

If you would like to enroll, switch your health plan or change your family status, you may do so during the annual Open Enrollment period or within 30 days of a major family status change event (birth, death, marriage, divorce, change in job status).

If you are already enrolled in the health plan, you will be automatically re-enrolled at your current coverage status. No forms are needed.

Re-enrollment is required each January for the new plan year for Dependent Care, Limited Purpose or Medical Flex Spending Accounts or to elect HSA contributions.

DENTAL PLAN

If you would like to enroll, add, change or drop dependent(s), now is the time you are able to do that. If you are currently enrolled and do not have any changes, you will be automatically re-enrolled at your current coverage status. No forms are needed.

VISION PLAN

If you would like to enroll, add, change or drop dependent(s), now is the time you are able to do that. If you are currently enrolled and do not have any changes, you will be automatically re-enrolled at your current coverage status. No forms are needed.

LIFE, AD&D & LTD PLANS

All benefit-eligible employees are enrolled in this plan. Now is a good time to review your beneficiary designation for your life and AD&D policies.

VOLUNTARY LIFE, AD&D & STD

To enroll in these plans, forms must be filled out, including Evidence of Insurability, and returned.

QUESTIONS? NEED FORMS?

Contact a member of your HR "Total Employee Rewards" Team

CARRIER QUICK LINKS

Health plan:

UMR-

Call customer service at 800-826-9781 or call the phone number on the back of your ID card or visit www.umr.com.

Dental Plan:

Delta Dental-

Call customer service at 800-236-3712 or call the phone number on the back of your ID card or visit www.deltadentalwi.com.

Vision Plan:

EyeMed-

Call customer service at 844-225-3107 or call the phone number on the back of your ID card or visit www.eyemed.com.

HSA and FSA:

Optum-

Call customer service at 844-973-3925 or call the phone number on the back of your ID card or visit optumfinancial.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

What is an EAP?

An Employee Assistance Program (EAP) is a confidential program that is available to you at no cost. It is here to assist you with important matters that will help you maintain balance outside of the workplace. This program is administered by Empathia.

What services does Empathia provide?

Work/Life Services

- Assistance Searching for the following resources
- Childcare
- Eldercare
- Education
- Adoption

Financial Services

- Financial consultation with certified credit counselors
- Debt consolidation
- Credit report reviews
- Financial planning and budgeting

Legal Services

- Free initial consultation for:
- Divorce/custody
- Domestic disputes
- Real estate
- Personal injury
- Estate planning
- Adoption
- Will Kits for Simple Wills
- Six-page document review

Identity Theft Services

Website Features:

- Topical libraries
- Financial calculator
- Interactive online learning
- Online health assessment

And more!

EMPATHIA

24/7: Telephone, Online & Mobile Counseling:

- **Relationships**
- **Stress Management**
- **Legal**
- **Mental Health & Addictions**
- **Elder Care**
- **Financial**
- **Child Care**

Visit Empathia at **mylifematters.com** **(password Elm1)** 24 hours per day, 7 days per week, 365 days per year.

1-800-634-6433

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403(b) AND 457 PLANS

Elmbrook Schools offers a 403(b) plan to help eligible employees save for retirement. All employees, with the exception of private contractors, appointed/elected trustees, school board members and student workers, are eligible to participate. The plan allows for contributions on a tax-deferred basis or a Roth (after-tax) basis. The 403(b) plan is administered by TSA Consulting Group, Inc.

Employees can contribute up to 100% of their income, up to the annual limit as set by the Internal Revenue Service. Traditional, or tax-deferred, contributions are made on a pre-tax basis from the employee's payroll so the employee's taxable income is reduced. Taxes on contributions and any earnings are deferred until the employee withdraws their funds. Roth, or after-tax, contributions do not reduce the employee's taxable income as they are deducted from the employee's payroll after taxes are calculated. All qualified distributions from a Roth 403(b) are tax-free and any earnings are tax-free as long as the account's first contribution is at least five years old at the time of distribution. Employees are fully vested in their contributions and earnings at all times.

Employees can choose where to invest their money from the approved vendors list that best suits their needs. Once an account has been established with the provider, a Salary Reduction Agreement (SRA) form and any disclosure forms must be completed and submitted to Elmbrook Schools' Payroll Department. This form authorizes Elmbrook Schools to withhold contributions from the employee's paycheck and send the funds to the provider. Employees can enroll and/or make changes to their contribution amounts any time during the year by completing a new SRA.

Employees can also enroll in a 457 plan through the Wisconsin Deferred Compensation Program (WDC). A 457 plan is a voluntary retirement savings program. As above with the 403(b) plan, employees can elect to contribute pre-tax or after-tax/Roth dollars through payroll deductions, up to the annual limit. If interested in enrolling, employees should register with WDC (https://wdc457.empower-retirement.com/participant/#/register/) and select their contribution amount and investments. It is recommended to consult with a financial advisor prior to enrolling. There is also investment assistance available through WDC for a fee based on the account balance.

For more information on 403(b) plans, please visit www.tsacg.com or call 888-796-3786. For more information on 457 plans, please visit www.wdc457.org or call 877-457-9327.

Wisconsin Retirement System (WRS)

The Wisconsin Retirement System (WRS) is a pension plan that is intended to provide employees with a lifetime retirement payment (annuity) once they are vested and have reached minimum retirement age. Both the employee and Elmbrook Schools are required to contribute to this retirement pension. Contribution rates are a percentage of earnings and each year the percentage can change per WRS, but it is always split 50/50 between the employee and Elmbrook Schools.

Employees are eligible if they become a WRS employee on or after July 1, 2011 (with no service prior to July 1, 2011) and:

-are expected to work at least two-thirds of full-time employment (1,200 for non-teaching and 880 hours for teachers and school district educational support personnel) and

-are expected to be employed for at least one year

Employees who became an employee before July 1, 2011, will become an eligible employee if they:

-are expected to work at least one-third of what is considered full-time employment (600 hours for non-teaching employees and 440 hours for teachers and school district educational support personnel) and

-are expected to be employed for at least one year

Contributions are automatically placed in a Core Fund which is a fully diversified and balanced trust fund. The goal of this fund is to earn an optimum long-term return while taking acceptable risk so it includes a mixture of stocks, bonds and real estate to stabilize the effects of market changes. Investment returns are smoothed over five years to give a more stable rate of return each year. Employees can elect to deposit 50% of all contributions into the Variable Fund which is primarily a stock fund. The goal of the Variable Fund is to attain returns equal to or greater than that of similar stock portfolios over a market cycle. Unlike the Core Fund, returns on the Variable Fund are not smoothed which means the full rate of return, either positive or negative, is recognized each year. WRS mails statements to employees' homes once a year.

In order to be eligible for a retirement benefit that includes the employer contributions and the associated interest, an employee must be vested and at minimum retirement age. Vesting refers to the minimum number of years of employment that is needed. The vesting rules depend on when an employee's WRS employment first began:

-If WRS employment first began after 1989 and terminated before April 24, 1998, then employees must have some WRS-creditable service in five calendar years.

-If WRS employment first began on or after July 1, 2011, then employees must have five years of WRS-creditable service.

-If neither statement above applies, then an employee was vested when WRS employment first began.

For those employees that began WRS employment on or after July 1, 2011, the full-time equivalent of one year of creditable service is

- 1,320 hours for a teacher
- 1,904 hours for all other employment categories

WRS uses two methods of calculations (Formula and Money Purchase) to determine the retirement benefit an employee will receive; the employee will automatically receive the higher amount of the two methods. At the time of retirement, employees choose an annuity option; all annuities are paid for the employee's lifetime but the options differ in what happens after the employee passes away.

For more information, please visit www.etf.wi.gov or call 877-533-5020.

APPROVED 403(B) VENDOR LISTING

Ameriprise Financial - 403(b)
70100 Ameriprise Financial Center
Lincoln, NE 55474
www.ameriprise.com
800.862.7919

AXA Equitable Life Insurance Company - 403(b) / Roth 403 (b)
Ryan Haslbeck - ryan.haslbeck@axa-advisors.com
500 Plaza Dr., 7th Floor
Secaucus, NJ 07094
www.axaonline.com
800.628.6673

MetLife Resources - 403(b) / Roth 403 (b)
400 Atrium Drive
Somerset, NJ 08873
www.metlife.com
800.560.5001

Security Benefit Life Insurance Company - 403(b) / Roth 403 (b)
One Security Benefit Place
Topeka, KS 66636
www.securitybenefit.com
800.888.2461

Voya Retirement Insurance and Annuity Company (formerly ING) - 403(b) / Roth 403 (b)
One Orange Way,
A3S Windsor, CT 06095
www.voya.com
800.584.6001

WEA Tax Sheltered Annuity Trust - 403(b) / Roth 403 (b)
Kelly Behnke - kbehnke@weabenefits.com
P.O. Box 7338
Madison, WI 53707-7338
www.weabenefits.com/retirement
800.279.4030 ext. 6636

edvest

COLLEGE SAVINGS MADE SIMPLE

EMPLOYEE PAYROLL DIRECT DEPOSIT INSTRUCTIONS:

STEP 1

Open an Edvest account at Edvest.com. On the Funding Method page, select Payroll Direct **Deposit** and enter any dollar amount to be contributed each pay period. Upon completing thesteps to open a new account, print or view the form with payroll direct deposit instructions.

If the employee has an existing Edvest account(s), then log into the account at **Edvest.com.** Go to the "Profile & Documents" section on the home screen and select "Payroll Direct Deposit", then "Change payroll instructions". Enter the dollar amount per paycheck and select "Next". View or print the payroll direct deposit instructions by selecting "Get Form".

STEP2

Follow the payroll direct deposit instructions you printed. Input the below routing instructions into Skyward Employee access by following steps on next page.

Direct deposit routing instructions:

Account Type: Checking
ABA Number: 011001234
Account Number: 584 + first 9 digits of Edvest account number

THAT'S IT

Please note, the first direct deposit to Edvest may take 1-3 pay periods. To change or stop your payroll direct deposit, you must notify your employer.

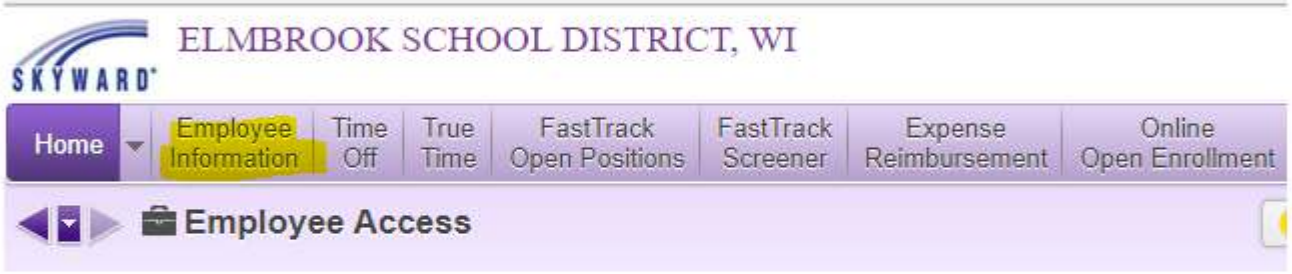
ENTER SECONDARY DIRECT DEPOSIT ACCOUNT IN SKYWARD

Add/Update/Change your secondary bank, add a secondary bank (choose *Add Deduction Bank)* etc. (EDVEST)

Direct deposit changes take about a full week to complete.

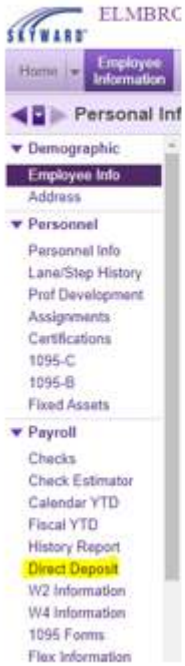
To add direct deposit routing instructions for Edvest direct deposit routing instructions:
Log on to Skyward and go to Employee Access.

Choose Employee Information



Choose Personal Information

Choose Direct Deposit Under payroll



Choose Add Deduction Bank

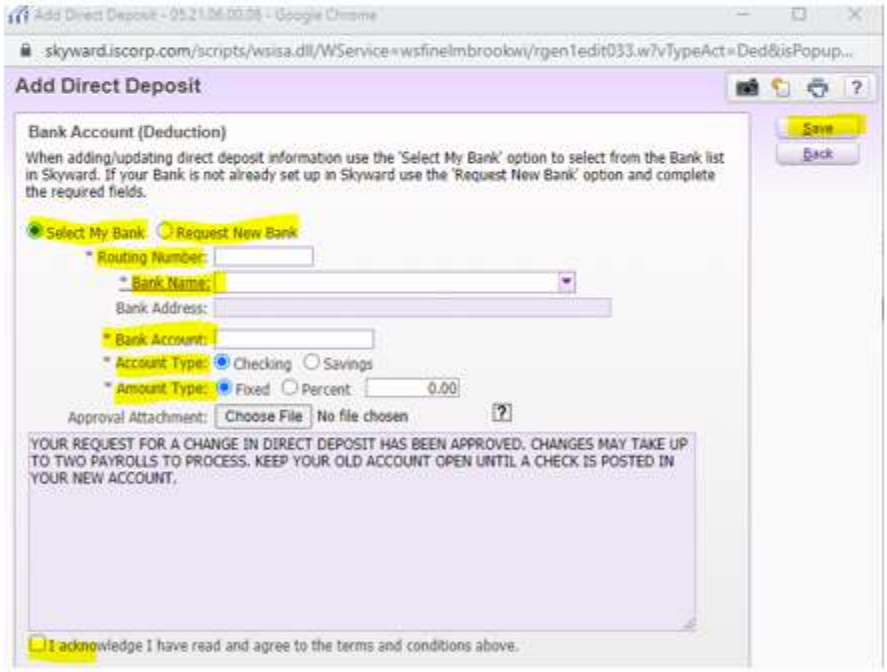
Fill in all information. Check the "I acknowledge box" and save.

Enter the information from Edvest:

Account Type: Checking

ABA Number: 011001234

Account Number: 584 + first 9 digits of your Edvest account number



These are sent to payroll for approval. Please 3-5 days for processing.

DirectPath

Elmbrook Schools
become what's next

... and welcome to DirectPath!

Elmbrook School District has partnered with DirectPath as a confidential, no-cost resource for answers to your benefits or health care questions throughout the year.

Your DirectPath Advocate can:

- Explain how your benefits work
- Resolve claims and billing issues
- Assist with referrals and prior authorization
- Compare pricing for an upcoming test, procedure or prescription drugs
- Find a doctor
- Provide you access to registered nurses for diagnosis, procedures and medication options

We're here to help. Contact us via phone or email to reach an advocate for assistance!

Get rewarded with 20% of the savings up to $1,000 for selecting a lower-cost option for your medical tests and procedures! Call DirectPath for details.

advocate@directpathhealth.com

@DirectPathHLTH

DirectPath is completely confidential and provided as part of your benefits program at no cost to you!

(866) 253-2273

advocate@directpathhealth.com

MONDAY-FRIDAY:
7:00am – 8:00pm CT

SATURDAY:
8:00am – 1:00pm CT

DirectPath

Elmbrook Schools
become what's next

GREAT NEWS!

You now have access to DirectPath support throughout the year. Here's what you need to know.

DirectPath Advocates are available to assist with any benefits or health care concern. Here are a few common scenarios to demonstrate how DirectPath can support you and your covered dependents:

I'm new to the company and to benefits. I don't really understand my options.

DirectPath can explain the benefit options and help identify the best choices for her unique situation.

I have some medical procedures coming up. How can I save on costs?

DirectPath will provide a cost comparison report showing up to three options. If the employee selects a lower-cost option, not only will he save on his medical expenses, he will be rewarded* with 20% of the savings (up to $1,000!)

I am interested in the COVID-19 vaccine, but I don't know how to find an appointment near me.

DirectPath can answer questions about COVID-19 and the vaccine, and can assist with finding a vaccination appointment.

I just moved, and I need help finding a doctor in my new city.

DirectPath will find high-quality, in-network physicians in the area --and even set up an appointment.

Help! My claim was denied and now I have a huge medical bill.

DirectPath will review the employee's claim to determine whether it was coded incorrectly, and begin the appeals process. They'll also carefully review all medical bills for errors and work to have corrections made.

I turn 26 this year and need my own benefits. What's the process?

DirectPath will explain the Qualifying Life Event process as well as benefit options available through the company and on the marketplace.

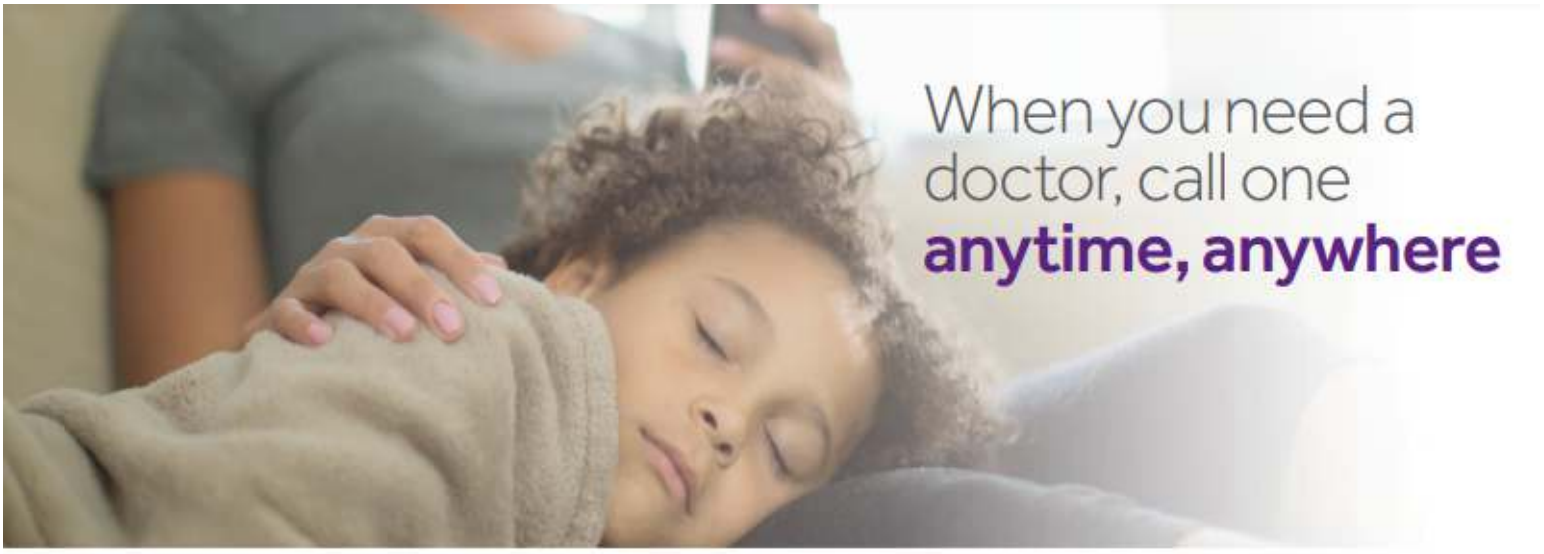
DirectPath is completely confidential and provided as part of your benefits program at no cost!

(866) 253-2273

advocate@directpathhealth.com

M-F: 7:00am –8:00pm CT

SAT: 8:00am – 1:00pm CT



TELADOC. | Elmbrook Schools become what's next

Skip the trip to the waiting room. With Teladoc, you can talk with a doctor within an hour by phone or app from wherever you are.

Know your care options

Teladoc
For non-emergency conditions like the flu, allergies, infections, and much more. Our doctors can also prescribe medicine, if needed.

General practitioner
For annual exams and ongoing medical conditions needing regular monitoring.

Urgent care/ER
For severe conditions like chest pain, sprains, cuts, burns, or broken bones.

Feel better when you need to with Teladoc

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

10E-194C_349701825_08202018

LEVELS OF CARE

Selecting the right care at the right time provides members with the right cost and outcome. Here's a guide to choosing the right level of care.

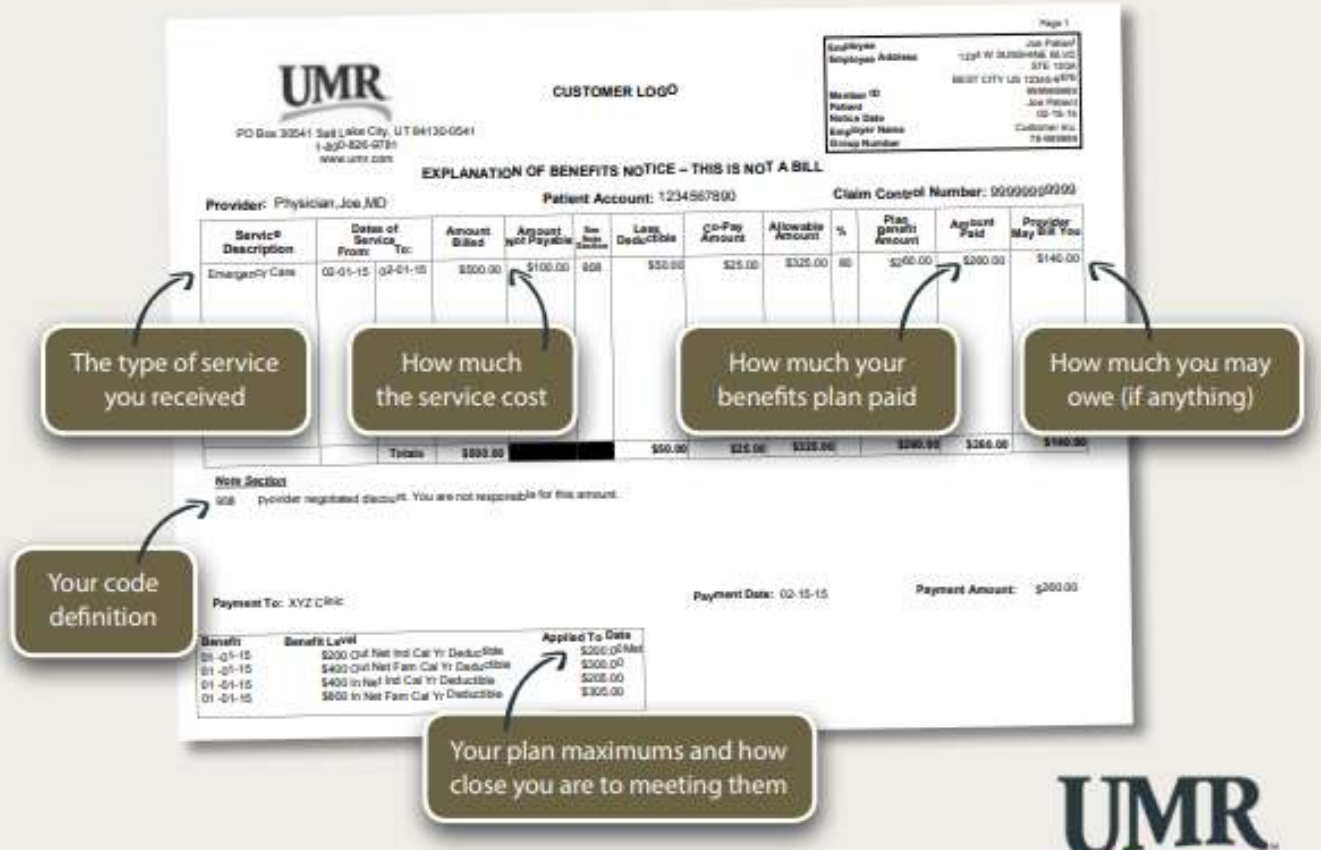
You deserve an explanation

An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about your claims.

Among the more important things included on your EOB are:

- The service you received
- How much the service cost
- How much you may owe, if anything
- A notes section that explains the meaning of any special codes
- A section that shows how close you are to meeting any plan maximums

There is a second page that includes contact numbers if you have questions. It also tells you how to file an appeal if you want a claim decision reviewed.



UMR
A UnitedHealthcare Company

10 ways to control health care costs

Everybody can play a role in controlling the rising cost of health care. In fact, there are many things you can do to reduce how much you spend on health care now and in the future.

▸ See preferred doctors

Most health plans let you see any doctor you want. But you can save a bundle by seeing doctors that are part of your plan's preferred network of health care providers. Going to a preferred, in-network doctor usually saves you 20% to 30% or even more off your bill.

▸ Go generic

Generic drugs are the same as other medications, just without the brand name. The biggest difference is the price. Generics usually cost you 30% to 70% less than brand names.

▸ Practice prevention

Preventive care includes things like physical exams, vaccines, blood tests and cancer screenings. These services can prevent you from getting sick or detect a health issue before it gets serious. Check your health plan to see if preventive care is covered in full or at discounted rates.

▸ Get online

It makes sense to find out everything you can to make informed, cost-saving health care choices. That's why we offer a number of web tools to help you review your health care options, pharmacy benefits and health coverage estimates usingthe Internet. Visit our website at **umr.com**.

Fast fact

Generic drugs usually cost you 30% to 70% less than brand names.

▸ Choose the right care

There is a time and place for everything. A trip to the emergency room may be needed if you are seriously injured or ill. Consider a cheaper option, like a walk-in clinic or urgent care, if you have a minor illness or issue, such as an ear infection. It may save you time as well as money.

▸ Think long-term

Some people go to the doctor for minor reasons once they meet their yearly deductible. While that may not have an instant impact on health care costs, it is a major factor in driving up everyone's overall costs of care.

▸ Eat right

A balanced diet can save you money. It keeps you healthier in the short-term and lessens the chances of developing more serious and costly medical conditions in the future.

▸ Exercise

Just 30 minutes of walking or other regular exercise each day helps manage weight, stress and possibly your pocketbook. Exercise helps control and prevent high blood pressure and cholesterol, two of the major risk factors for heart disease.

▸ Take care of yourself

The harmful effects of unhealthy habits, such as tobacco use and alcohol abuse, are well known in regard to health issues like cancer and heart disease. If you use tobacco products, seek help to try quitting. Practice moderation if you drink alcohol. Get help if stress or depression are an issue. You will feel better and also save a few dollars.

▸ Review your EOB

Billing mistakes sometimes happen. Review your explanation of benefits (EOB) statement to make sure you are properly billed. Contact your doctor or other care provider if you suspect an incorrect charge.

Review your explanation of benefits (EOB) statement to make sure you are properly billed.

UMR
A UnitedHealthcare Company

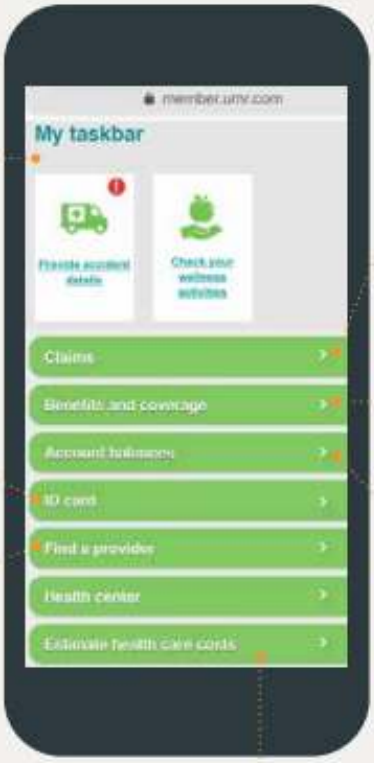
Welcome to
umr.com on the go

As a UMR member you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download. Simply log in to **umr.com**

My Taskbar
View upcoming tasks right from the homepage.

Share your ID card with your provider
Now, there's no need to carry it with you, it's at your finger tips

Find a provider
Find an in-network provider while you are **"on the go."**



Look up claims
Look up a claim for yourself or an authorized dependent.

Check your benefits
View medical/dental benefits. And, see who's covered under your plan.

Access account balances
Look up balances for your special accounts including HRAs and FSAs.

Estimate health care costs
See what you can expect to pay before receiving care with the Health Cost Estimator tool.

Want to bookmark umr.com on your mobile device?

iPhone: Touch and hold the open book icon to add **umr.com**

Android: Tap on the menu. Then select "Add Bookmark."

Note: The images above reflect available features within our mobile site. These features may or may not be available to all users depending on your individual and company benefits. If you are having trouble accessing or logging into our mobile site, contact the 800 number on the back of your ID card for fastest service. You can click the "Contact us" link on the home screen.

UMR
A UnitedHealthcare Company

Email notification options and **umr.com**

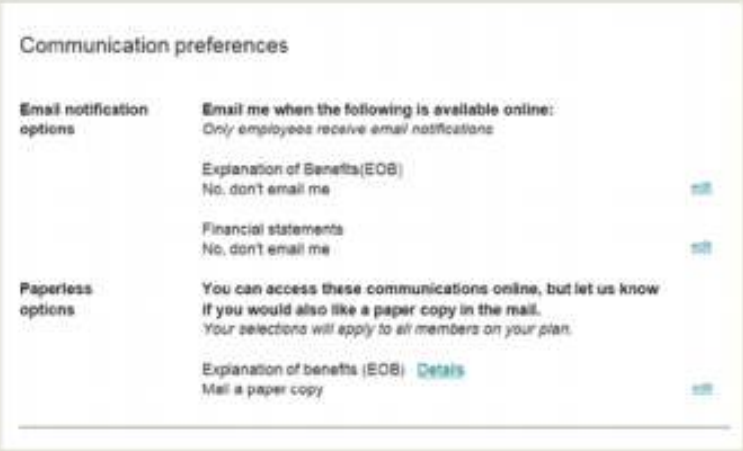
A UnitedHealthcare Company

Selecting your communication preferences and access privileges

You have options regarding your communications from UMR and private information. Here's how to update:

Step 1: Plan holders must create an account on **umr.com**. Any dependent over age 18 (child or spouse) will also need to create their own **umr.com** account.

Step 2: Under **Account settings** in the **Access privileges** section, the dependent can identify who should have access to his or her information. Dependents can grant access to any other dependent over 18 years of age in the **Account settings** tab. To make any changes to access privileges, simply click the edit button within that section, and make sure to save changes.



Step 3: The plan holder must also create an account on **umr.com**. Once registered, plan holders can update communication preferences in the **Account settings** section. Under **Communication preferences,** you can choose to have EOB and financial statement notifications emailed to you as they are available. (You will still need to log in to umr.com to access these communications). You can also elect to have EOBs mailed to you in paper form. *Reminder: Selections for paper and paperless options apply to all members on your plan.*

UMR and the UnitedHealthcare **Premium Designation Program**

Ideally, better health coverage should cost less. In reality, now it can.

A plan designed with both quality and affordability in mind. Consistent, quality care is vitally important.

When you need a physician, you want to make informed choices. Welcome to the Premium Designation program available through UMR.

- Enjoy one of the nation's largest networks of physicians. Almost anywhere in the United States you'll find participating doctors, hospitals or pharmacies for the same coverage levels you get at home.
- Make the most of preventive care coverage, so little concerns don't become big problems later (see your specific plan for details).
- Access Premium Designation information at your fingertips on **umr.com**

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Physician Designations

PREMIUM CARE PHYSICIAN

The physician meets the UnitedHealth Premium® Program criteria for providing quality and cost-efficient care.

QUALITY CARE PHYSICIAN

The physician meets the Premium program quality care criteria, but does not meet the program's cost-efficient care criteria or is not evaluated for cost-efficient care.

NOT EVALUATED FOR PREMIUM CARE

The physician's specialty is not evaluated in the UnitedHealth Premium Program. The physician does not have enough claims data for program evaluation or the physician's program evaluation is in progress.

DOES NOT MEET PREMIUM QUALITY CRITERIA

The physician does not meet the UnitedHealth Premium Program quality criteria, so the physician is not eligible for a Premium designation.

How the UnitedHealth Premium Program works

UnitedHealth Premium is an innovative program that evaluates eligible physicians against scientifically defined medical guidelines for quality and cost efficiency.

Physicians must first meet quality of care guidelines – and only then are they evaluated for their cost efficiency. Once physicians have been evaluated, they will be given a heart designation based on the results.

UnitedHealth Premium Quality of Care designation

When evaluating quality of care, we review a physician's performance against nationally accepted standards from medical organizations and governmental agencies such as the Ambulatory Care Quality Alliance, the National Committee for Quality Assurance (NCQA), and the American College of Cardiology, as well as scientific advisory boards. This is important to you because following evidence-based care guidelines has been shown to have a positive impact on the quality of care and safety of patient care[1].

UnitedHealth Premium cost efficiency designation

Only those physicians who meet quality standards are then reviewed for cost efficiency. Efficiency evaluates the utilization and cost of medical and diagnostic resources.

Cost efficiency criteria are based on patient care provided over a two-year period, including the appropriate use of diagnostic testing, prescribed medications, the procedure itself, follow-up care and the associated costs.

Measurement also factors in the amount of re-do procedures and complication-related expenses.

We measure cost efficiency at the local level, because we recognize that there are differences in what it takes to deliver a service in one market versus another.

For more information on the UnitedHealth Premium Designation program, visit **umr.com**

[1] *Committee on Quality of Health Care in America, Institute of Medicine (2001), Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press.*

Maximize your health benefits

When you need a physician, maximize your health plan benefits by making sure the physician you choose has the UnitedHealth Premium Care Physician designation for quality of care and cost efficiency.

Finding the right physician is the most important thing you can do for your health care…

But it isn't always easy. We provide the information you need to help you make a more informed decision on where to seek care.

… and now, for your pocket book.

When you visit a physician who has UnitedHealth Premium designations for quality and/or cost efficiency, you may pay lower co-payments for office visits, and get higher plan co-insurance coverage.

TIER 1 Look for the blue Tier 1 dot.

It's important to choose carefully.

To get the most from your plan, find a quality and cost efficiency designated physician by visiting umr.com and click on Find a Physician or Facility. Look for a physician with the Premium Care Physician designation.

Your ID card includes a Customer Care phone number for easy access to designation information.

TIER 1

To find a UnitedHealth Premium-designated doctor, just look for the Tier 1 physician designation.

Physician care

The UnitedHealth Premium Designation Program includes 16 specialties and 47 sub-specialties

Allergy
Allergy
Allergy & Immunology

Cardiology
Cardiology
Cardiovascular Disease
Cardiac Diagnostic
Cardiology-Interventional
Clinical Cardiac Electrophysiology
Endocrinology

ENT
Otolaryngology
Otology
Pediatric Otalaryngology
Head and Neck Surgery
Laryngology
Rhinology

Endocrinology
Endocrinology, Diabetes and Metabolism

Family Medicine
Preventive Medicine
Family Practice
General Practice

Gastroenterology
Digestive Diseases
Hepatology-Liver Disease
Gastroenterology

General Surgery
Abdominal Surgery
Proctology
Colon & Rectal Surgery
Surgery

Internal Medicine
Internal Medicine
Internal Medicine Pediatrics
Geriatrics

Nephrology
Nephrology

Neurology
Neuromuscular Disease
Neurology
Neurology & Psychiatry

Neurosurgery, Orthopaedics & Spine
Orthopedic Surgery
Neurology Surgery
Shoulder Surgery
Knee Surgery
Back & Spine Surgery
Sports Medicine
Hand Surgery

Obstetrics & Gynecology
Gynecology
Obstetrics
Obstetrics & Gynecology

Pediatrics
Pediatrics
Pediatric Adolescent
Adolescent Medicine

Pulmonology
Pulmonary Medicine

Rheumatology
Rheumatology

Urology
Urology

You can find more information on the UnitedHealth Premium Designation program using the provider search tools on umr.com

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Know where to go when you need care.

When you need care quick, your first impulse may be to go to an emergency room (ER). But did you know that there are alternative options to treat your immediate care needs that could save you up to $1,800 or more compared to an ER?*

Before you wait for hours in the ER, call your primary care provider (PCP) or family doctor. Many doctors offer same-day appointments, but if that's not possible, you may be able to receive fast, professional care for much less at an urgent care center, convenience care clinic or an online doctor visit.

CHECK
your options for care

CHOOSE
your care provider

GO
for better health

continued

*Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. The information provided is for general informational purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 9-1-1 or go to the nearest emergency room.

Quick care options:

When seeing your physician is not possible, it's important to know your quick care options to find the place that's right for you and help avoid financial surprises. If you're not sure where to go, UMR's benefits specialists can help you decide.

	Teladoc Consults	Convenience Care Clinics	Urgent Care Facility	Emergency Room
Reason for Visit	• Urinary tract infections • Mild colds and flu • Mild vomiting or diarrhea • Mild fevers or headaches • Pink eye • Rashes • Sinus or ear infections • Sore throat	• Minor injuries • Mild vomiting or diarrhea • Allergies • Urinary tract infections • Rashes • Pink eye • Sinus or ear infections • Sore throat • Preventive care	• Animal and insect bites • More-severe-than-usual asthma • Mild vomiting or diarrhea • Minor burns or cuts that may need stitches • Sprains, strains and minor fractures	• Severe pain, especially in the chest or upper abdomen • Uncontrollable bleeding • Difficulty breathing, speaking or walking • Fainting or dizziness • Severe trauma or serious injuries
Average Cost	$	$$	$$$	$$$$

Call the member services number listed on the back of your ID card or visit **umr.com** to learn more about your care options and find a network provider near you.

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Looking for a health care provider?

Compare quality and costs before you go

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit **umr.com** first. Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment

Stay in-network

With **umr.com**, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

START SHOPPING TODAY

Log into **umr.com** and select Find a provider. Then choose View providers to search for medical providers. Or log in and look for the health cost estimator shopping cart icon to get started.

Check for quality

The two blue hearts next to a doctor's name tells you they are a Premium Care Provider who has been reviewed by UnitedHealthcare and meets quality standards for delivering cost-effective care.

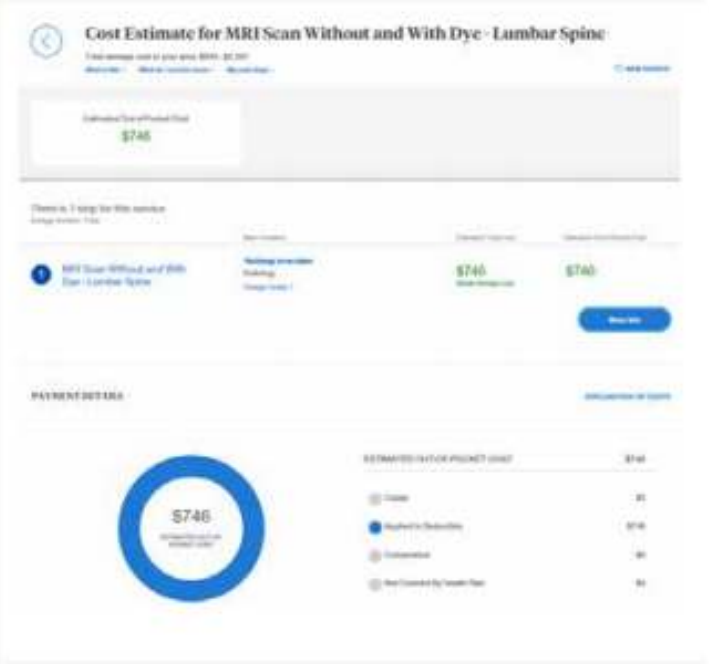
You may also see star ratings for customer satisfaction based on reviews from previous patients.

Understand the costs

Different providers may charge different amounts for the services they offer. Your search results will give you a range of the average costs for preventive care or medical procedures in your area. And the individual provider listings show whose costs are below, above, or meet the local average.

If a procedure typically includes multiple steps of treatment, you can review the total cost and your estimated out-of-pocket cost for each step. So you'll know what to expect, from start to finish.

Your estimated out-of-pocket costs are personalized to you, based on your own benefit plan's deductible, annual out-of-pocket max, co-pay, co-insurance and how much you've paid toward your deductible.



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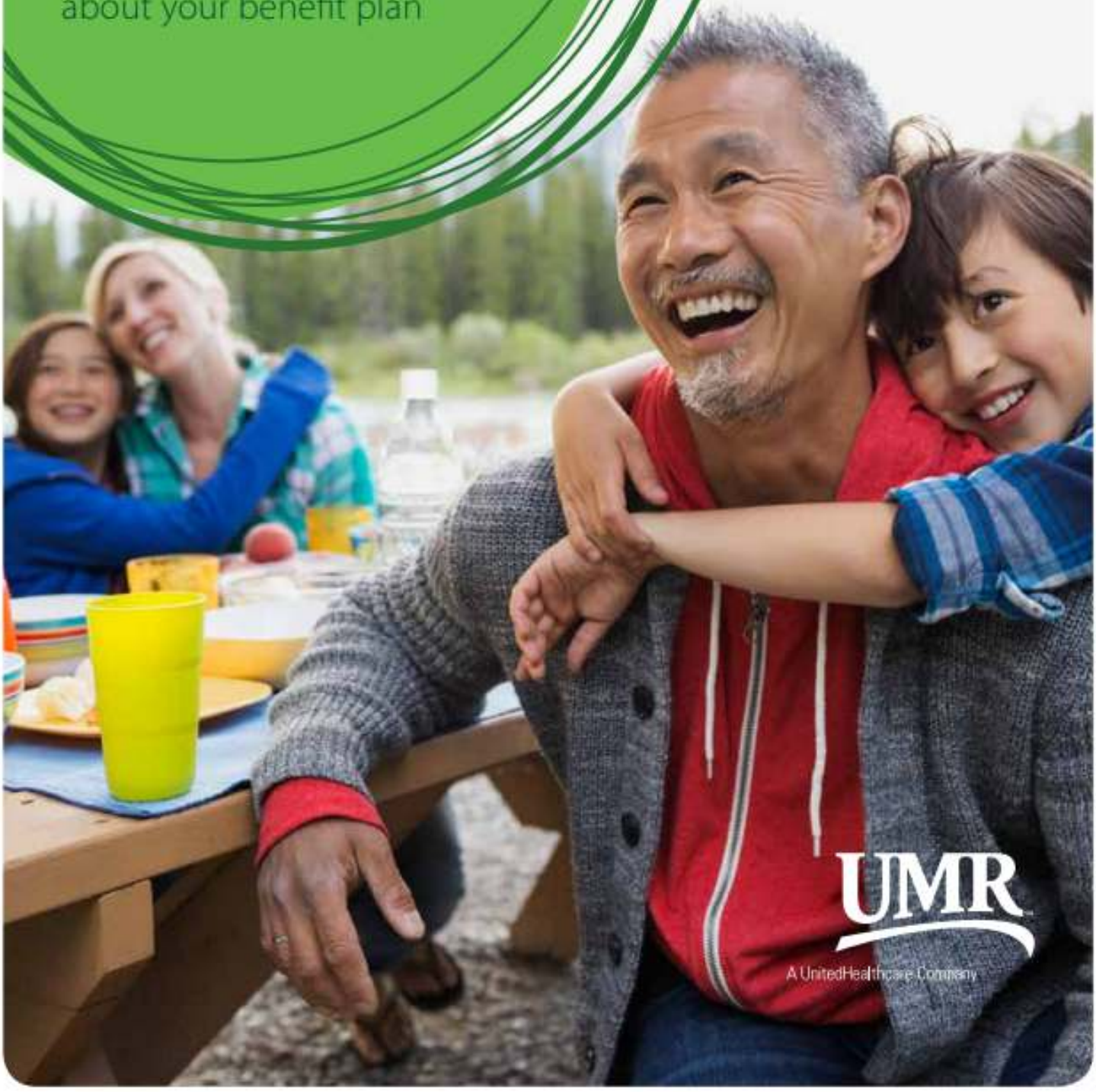
Frequently asked questions

What you need to know about your benefit plan



Your benefit plan FAQs ...

Q. Who is UMR?

A. UMR is a third-party administrator (TPA) that provides employers and health benefit plan members with services to help them get the most from their benefit plan.

Q. What is a TPA?

A. A TPA is a company that your employer hires to handle the many tasks associated with managing your health benefit plan. For example, UMR handles general enrollment tasks when new plan members sign up to receive health benefits. We also process your health claims, making sure they are handled quickly and accurately. UMR even has medical professionals on staff who can help coordinate your care if you are in the hospital or are dealing with a chronic health condition.

Q. What does it mean to be self-funded?

A. A self-funded benefit plan is financed by your employer, not an insurance carrier. Your employer pays for most of your health plan and claim costs.

Q. What is a PPO?

A. Most TPAs work with a preferred provider organization (PPO). A PPO is a network of health care providers who have agreed to discount (reduce) what they charge for services when treating members of a benefit plan. When you choose to see an in-network PPO health care provider, you will pay less for their services than if you had chosen an out-of-network (non-PPO) health care provider. You have the option to see non-PPO providers, but you will pay more for their services.

Your member ID card contains important information regarding your plan's PPO. Contact your PPO directly or your UMR customer service team to check a health care provider's participation.

Q. What does UMR do for me?

A. We provide you with prompt, personalized service. As a plan member served by us, you have a customer service team of helpful people available to assist you and answer questions about your health benefits. For example, you can ask us about the medical care your plan covers or about a specific health claim. One phone call is all it takes to reach us and speak to someone who can help you get the answers you need.

You may also receive other services, depending on your health plan's features, to help you and your covered family members use the health care system and receive appropriate health care at a reasonable cost.

Q. What can I do to reduce my health care expenses?

A. A lot! First, choose a participating PPO provider whenever possible, so you'll receive the discounts your plan has made available for you. Your benefit plan ID card displays your PPO information. Always show your ID card to your health care provider at each visit.

Learn about the features of your benefit plan, too, so you'll know about money-saving ways to receive your health care, like taking advantage of preventive care services.

Also, read and understand your EOB. It can help you track your health care costs and get a better handle on what you're spending. The "How to Read Your EOB" section in this brochure will help you understand how your health claims are charged, processed and paid.

And learn how you and your family can prevent illness and maintain your health. Make health-conscious choices every day. You'll feel better, improve the quality of your life and have more money you can use for other things – not health care!

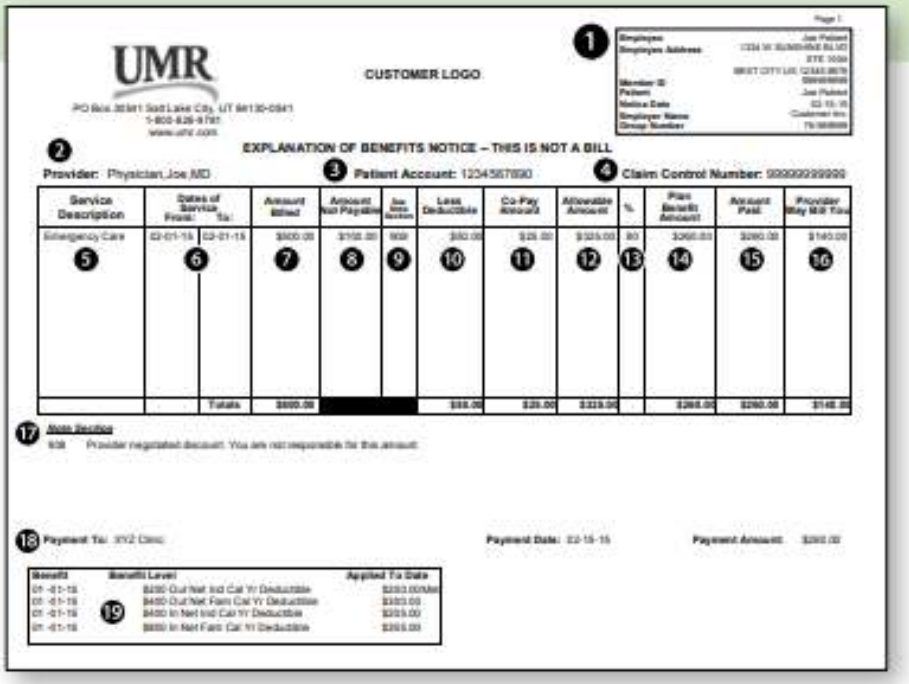
Q. Will I receive mail from UMR?

A. You may receive an explanation of benefits (EOB) for health claims submitted by your health care providers. Your EOB shows you important information, including what your plan pays and what portion of the bill is your responsibility.

You will not receive an EOB for claims where your responsibility is zero or only a co-payment. You can review your zero balance or co-payment claims on **umr.com** or by contacting a Customer First representative.

You may also receive letters from UMR if we need more information about a health claim in order to process it appropriately. Sometimes, we may send you letters that will require you to follow up with your provider to obtain more information. The requested information is important for timely completion of your claim. Feel free to call us if you have questions or need assistance with our request.

How to read your EOB



1. Fields include member information under which the claim was processed.
2. Hospital, physician or other health care provider that performed the services.
3. Account number assigned by the hospital, physician or other health care provider.
4. UMR assigns a unique claim control number to each claim received.
5. Services and/or procedures that were performed by the hospital, physician or other health care provider.
6. Dates(s) services were performed by the hospital, physician or other health care provider.
7. Amount charged for the services by the hospital, physician or other health care provider.
8. Charges not allowed according to the Plan – see comment code.
9. Refers to codes used to explain charges that were not allowed – see Notes Section.
10. Amount applied to the deductible.
11. Co-pay amount paid at office visit.
12. Charges allowed for payment – this is the difference between the "Amount Billed" and the "Amount Not Payable" and/or "Less Deductible" columns.
13. Percentage at which the Allowable charges are paid.
14. Amount actually payable by the Plan.
15. Amount that UMR paid to the provider.
16. Only amount you are responsible to pay to the hospital, physician or other health care provider, if applicable.
17. Explains codes provided in the "See Notes Section" column. Lists the specific code and its definition.
18. List of individuals or organizations to whom checks were issued.
19. Provides benefit period and benefit levels, amounts applied to individual/family deductibles and out-of-pocket maximums, if applicable.

Get all your answers quick and easy @ umr.com

Another service UMR provides for you is **umr.com** for fast access to a variety of useful information. Log in now to:

- See a personalized to-do list called "My taskbar" that highlights the most important tasks you need to complete
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life
- Ask us a question using the site's Contact Us e-mail service or Live Chat

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*

How to contact UMR

Go to umr.com

Visit your password-protected online benefit service via the login at umr.com. It's a fast, convenient way to get information and access services and resources provided with your benefit plan.

Use your ID card

Look for the Customer First service number on your ID card. Our UMR team is ready to help you. You will also find PPO contact information on your benefit plan ID card.

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WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. Notice regarding Wellness Program
2. HIPAA Portability Notice
3. Initial COBRA Notice
4. Notice of Exchange
5. Medicare Part D Coverage Notice
6. HIPAA Notice of Privacy Practices
7. Children's Health Insurance Program (CHIP)
8. Women's Health and Cancer Rights Act (WHCRA)
9. Michelle's Law
10. Newborns & Mothers Health Protection Act (NMHPA)

NOTICE REGARDING WELLNESS PROGRAM

The School District of Elmbrook offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for triglycerides and cholesterol levels. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of monthly premium co-pay savings (Monthly $60-Single, $60-Spouse, $120-Family) for completion of both the HRA questionnaire and biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive premium co-pay savings.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the School District of Elmbrook may use aggregate information collected to design a wellness program based on identified health risks in the workplace, the School District of Elmbrook will never receive and its partner, Everside, will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is Everside staff in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact a member of the "Total Employee Rewards" Team.

HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company's Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

Special enrollment rights
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 towards 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.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within **60 days** after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact a member of the "Total Employee Rewards" Team.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse, and dependent children when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the employer.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, and any required notice of that event is properly provided to the employer, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless the Plan sponsor has chosen to subsidize the cost of COBRA continuation coverage

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

Your dependent children will be entitled to elect COBRA if they lose group health coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. If these procedures are not followed or if the notice is not provided during the 60 day notice period, ALL QUALIFIED BENEFICIARIES LOSE THEIR RIGHT TO ELECT COBRA.

How is COBRA continuation coverage provided?
Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

This extension due to a second qualifying event is available only if you notify the employer in writing of the second qualifying event within 60 days of the date of the second qualifying event. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the individual health insurance carriers, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa** (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If you need more information, please contact a member of the "Total Employee Rewards" Team.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General information

When key parts of the health care law took effect in 2014, there began a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I save money on my health insurance premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit[1].

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact a member of the "Total Employee Rewards" Team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information about health coverage offered by your employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name: ___Elmbrook School District_____
2. Employer Identification Number (EIN):____39-1028780_____
3. Employer address: __3555 North Calhoun Road
   Brookfield, WI 53005
4. Employer phone number: __262-781-3030____
5. Who can we contact about employee health coverage at this job? Contact a member of the "Total Employee Rewards" Team.
6. Here is some basic information about health coverage offered by this employer

As your employer, we offer a health plan to:

☐ All employees. An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week or part-time 30-39 hours for non-teachers per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

☐ With respect to dependents:

☐ We do offer coverage. An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan may be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. Reference the Employee Handbook retirement addendums for retirement benefits and eligibility.

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare 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. Elmbrook School District has determined that the prescription drug coverage offered by the Elmbrook Health Plan 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 through 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 Elmbrook School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Elmbrook School District coverage, be aware that you and your dependents may not be able to get this coverage back right away or at all. Please review the Elmbrook School District health plan documents for details regarding eligibility and enrollment rights.

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 current coverage with Elmbrook School District 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 October to join.

For more information about this notice or your current prescription drug coverage…
Contact the person listed below for further information **Beth McCabe - Open Enrollment, HRA & Plan Coordination at (262) 781-3030 x1186 or mccabee@elmbrookschools.org**

NOTE: You'll get this notice each year. You will also get it if this coverage through Elmbrook School District 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 contacted directly by Medicare drug plans.

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 800-MEDICARE (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 800-772-1213 (TTY 800-325-0778).

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

Date:	September 1, 2021
Name of Entity/Sender:	Elmbrook School District
Contact--Position/Office:	Beth McCabe, Benefits & Wellness Specialist
Address:	3555 N. Calhoun Rd., Brookfield, WI 53005
Phone Number:	262.781.3030 x1186

HIPAA NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICE

Your information. Your rights. Our responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our uses and disclosures
We may use and share information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **877-696-6775** or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: we use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: we share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the department of health and human services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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 **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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – 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: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid – Medicaid and CHIP (Hawki)**
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	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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	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
INDIANA – Medicaid	**LOUISIANA – Medicaid**
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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**NEVADA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Main relay 711	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900

MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	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
MINNESOTA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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
MISSOURI – Medicaid	**NEW YORK – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MONTANA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NEBRASKA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855 632-7633 Lincoln: 402 473-7000 Omaha: 402 595-1178	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
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://greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.coverva.org/hipp/ https://www.coverva.org/en/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://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since **July 31, 2021**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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, Menu Option 4, Ext. 61565

Updated: 8/24/2021

NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women's Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women's Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

The School District of Elmbrook's Medical plans comply with these requirements. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your elected Medical plan.

If you would like more information on the WHCRA benefit, contact a member of the "Total Employee Rewards" Team or your UMR Customer Service Representative at 1-800-236-8672.

SCHOOL DISTRIC OF ELMBROOK MICHELLE'S LAW NOTICE

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The School District of Elmbrook's Medical plans (the "Plan") currently permits an employee to continue a child's coverage to age 26. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status, if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

> *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
>
> *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
> - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
> - which is medically necessary
> - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

> One year after the first day of the leave of absence
> The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full- time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

NEWBORNS & MOTHERS HEALTH PROTECTION ACT (NMHPA) DISCLOSURE

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 a vaginal delivery, or less than 96 hours following a cesarean section. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- However, the attending provider may decide, after consulting with the mother, to discharge the mother or newborn child earlier.
- The attending provider is any individual licensed under state law to provide maternity or pediatric care and is providing such care to a mother or newborn child. This may include a physician, physician assistance or nurse midwife; however, this may NOT include a health plan, insurer or hospital.
- The NMHPA prohibits incentives (either positive or negative) that encourages less than the minimum protection under this Act.

* Source: US Department of Labor, Employee Benefits Security Administration. *Compliance Assistance Guide: Health Benefits Coverage Under Federal Law,* Washington, DC: October 2010, p. 108, available at http://www.dol.gov/ebsa/pdf7CAG.pdf. Language used in the model appears in the final HIPAA portability regulations at 29 CFR § 2520.102-3(t)(2).


ELMBROOK HEALTH PLAN PARTNERS
Elmbrook Schools
TELADOC
800.835.2362
teladoc.com
Virtual Medical Provider
24/7/365 Physician Care
Urgent & After Clinic Hours
$45/Virtual Visit-Anywhere
Rx prescribed, if needed
Behavioral Health Providers Available
ELMBROOK SCHOOLS Family Wellness Center
DIRECT LINE | 262.214.1101
elmbrookschools.org/wellnesscenter
SCHEDULING LINE | 866.959.9355 for after hours
In-Person & Virtual Visits
Quality, Convenient, Cost Savings
Enhanced Pediatric Services
Understands Your Health Plan
Coordinates Care w/ Partners
Meds Available On-site and Prescribed
DELTA DENTAL
deltadentalwi.com
800-236-3712
Delta Premier/PPO Network
100% coverage for Preventative, Diagnostic & Basic, 80% for Major
EMPATHIA
GOOD FOR PEOPLE. GOOD FOR BUSINESS.
800-634-6433
mylifematters.com
Employee Assistance Program
24/7 Counseling & Support
No Cost, Confidential
Life, Work, Family, Well-being
ALL Staff Availability
DirectPath
advocate@directpathhealth.com
866-253-2273
Mon-Fri: 7AM-8PM CST, Sat: 8AM-1PM CST
Helps you understand your benefits
Compare costs for tests, procedures & Rx
Assist with referrals & prior authorization
Access to registered nurses for diagnosis, procedures & medication options
Resolve claims & billing issues
Find in-network providers
eyeMed
eyemed.com
866-804-0982
Insight Network
Co-pays & discounts for services and materials
WORKPLACE WELLNESS
WELLNESS CHAMPIONS
elmbrookschools.org/wellness
Wellness Program Advocates
"Total Rewards" Communications
Help with Access to Resources
Support For ALL Staff
Champions at each District location
OPTUM
844-973-3925
optumfinancial.com
Health Savings Account
District Contributions
Limited Purpose & Dependent Care Flex Spending Accounts
Savings & Tax Incentives
Investment Options
Debit Card
UMR
800-826-9781
umr.com
Benefit Accumulations & EOB Statements
Find Network Providers
Health Cost Estimator
Customer Service
View claims
CVS caremark
866-818-6911
caremark.com
Discounted Rx Manager
Mail Order Savings, Specialty Pharmacy
No Cost Meds Endorsed
90-Day Supply-CVS Retail & Mail Order
(Includes Target Stores)

School District of Elmbrook

TOTAL EMPLOYEE REWARDS

Human Resources, Benefits & Payroll Team

Kristin Sobocinski
Asst Superintendent for Business Services

Human Resources	Focus Areas	Email	262-781-3030
Pam Casey *Director of Human Resources*	• Direct Human Resources daily operations • Certified staff recruitment and job offers • Contract renewals & negotiations • Talent acquisition and retention strategy • Staffing plan development • Handbook, policies and procedures • Compensation strategy management	caseyp@elmbrookschools.org	extension: 1178
Beth McCabe *Benefits & Wellness Specialist*	• Total Employee Rewards Strategy • Total Employee Rewards Benefit Plans/Education/Communication • Open Enrollment • Health Risk Assessment/Biometric Screenings/Shoo the Flu/Measles titer • Wellness Center Coordinator • Workplace Wellness Coordinator • Retirement-OPEB/Retirees • Affordable Care Act/1095's • Retirement for All Ages Presentation Fair • Financial Wellness Fair	mccabee@elmbrookschools.org	extension: 1186
Linda Hordyk *Benefits Assistant*	• Benefit Enrollment/Terminations/Qualifying Events • Measles Task administration • COBRA Administration • Unemployment Forms/Reports • Address Changes • FSA - Daily Balance • Organization Charts/Expense Org Chart • Run UMR Report for age 26 Dep	hordykl@elmbrookschools.org	Extension: 1136
Lisa Jennaro *Senior HR Specialist, Leave Administrator*	• Paid Leave Administrator • FMLA, Leave of Absence, STDi & LTD admin • Substitute Coordinator short and long term • Teachers on Call liaison • AESOP/Frontline Administrator • Student teachers and Field Experience • Backup New Hire Onboarding • Employee Recognition • Workers' Compensation Coordinator • Employee calendars	jennarol@elmbrookschools.org	extension: 1121

Human Resources	Focus Areas	Email	262-781-3030
Sarah Leatherman *Talent Acquisition Specialist*	• Offer of hire- support staff • Performance management - all staff • Assistant Roundtable facilitation • Professional development - support staff • Onboarding new staff • EE Teacher Evaluation Process and Support • Support Staff Evaluation Process and Support • Teacher Career Promotion Process • Oversee DPI, state and federal reporting • Certified Staff Licensing • Summer School staffing • Recruitment/talent acquisition	leathers@elmbrookschools.org	extension: 1133
Marlee Johnson *HR Executive Assistant*	• Job postings • FastTrack assignments & assistance • Interview support • New hire onboarding & processing • Background checks for employees • Personnel Matters • SafeSchools data entry • Volunteer management • Personnel Committee support • BIB & Raptor • FileBound - Checking Completed Paperwork • CCAP Alert • Creating State ID for Skyward • Monitors HR Inbox • HireVue Process	johnsmar@elmbrookschools.org	extension: 1125
Mary Kaminski *Payroll Coordinator*	• New hires, changes and exits/COBRA • Payroll • Active employee benefits add/changes/exits • WRS administration • W2 Processing	kaminsma@elmbrookschools.org	extension: 1185
Eileen Zingale *Budget Staffing Coordinator*	• Employee Management • Extra Pay Contracts • Direct Deposits for Payroll • Tax Forms - W4 • True Time Hourly payroll • Timesheet Approvals	zingalee@elmbrookschools.org	Extension: 1131

RESOURCE PAGE:

Health Summary Plan Description 2020: https://www.elmbrookschools.org/fs/resource-manager/view/fc712f78-523a-4327-8a76-41569352c72d

Delta Summary Plan Description: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/delta_summary_plan_description.4-2006.pdf.pdf

EyeMed Summary Plan Description: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Total_Employee_Rewards/Eye_Med_Final_Benefit_Summary_School_District_of_Elmbrook_2020-01-01.pdf

HSA Summary of Benefits and Coverage: https://www.elmbrookschools.org/fs/resource-manager/view/65813b0f-3dab-4f33-b48a-b339aa08481e

COBRA Notice: https://www.elmbrookschools.org/fs/resource-manager/view/48e7f855-858c-47d8-a3c6-11c5662379fa

Creditable Coverage Notice: https://www.elmbrookschools.org/fs/resource-manager/view/0fcd3a57-00ed-4bdb-9def-4133bd2c013e

HIPAA Notice of Privacy Practices: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Total_Employee_Rewards/HIPAA_Notice.pdf

Women's Health and Cancer Rights Act (WHCRA) Notice: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/Womens_Health_and_Cancer_Rights_Act_(WHCRA)_Notice.pdf

Newborns Act Disclosure: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/Newborns_Act_Disclosure-11.12.2016.pdf

Michelle's Law Notice: https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/michelle's_law.pdf

CHIPRA Wisconsin Badger Care CHIP Notice: https://www.elmbrookschools.org/fs/resource-manager/view/38083978-0e4a-4ae3-845a-bf938e74b119

RESOURCE PAGE (Continued):

- **Notice Regarding Wellness Program:** https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/NOTICE_REGARDING_WELLNESS_PROGRAM.pdf
- **New Health Insurance Marketplace Coverage Options Notice:** https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/Required_Notices/New_Health_Ins_Mktplace_Covg_Options_Notice_(Expires_05_31_2020).pdf
- **Employee Handbook:** https://www.elmbrookschools.org/fs/resource-manager/view/34b31f68-dfdb-43f6-8b61-43a26a3caeda
- **OPEB Document:** https://www.elmbrookschools.org/uploaded/SSMigration/data/files/gallery/ContentGallery/OPEB_22415.pdf
- **District Retirement Benefit Summary:** https://www.elmbrookschools.org/fs/resource-manager/view/898c8d45-9fbe-4fb6-af6c-47c553b47c1a
- **Voluntary Life Rate Table:** https://www.elmbrookschools.org/uploaded/Documents/District_Documents/Benefits/life_insurance/SUPP_LIFE-AD_D_AND_DEP_LIFE_RATE_TABLE_(1).pdf
- **Payroll Premium Co-Pay Deduction Schedule:** https://docs.google.com/spreadsheets/d/1VkSM2hJXCmfONZ6EWTBTjhfXoUh9KTUH_KMAWV7Dm1M/edit?usp=sharing

This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

Your employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.

Information provided by USI Insurance Services.