Rockwood School District












Benefit Enrollment Guide

Standard Benefits – Retirees

Plan Year November 1, 2025 – October 31, 2026

Table of Contents

A Message to Our Retirees

Your Benefits Open Enrollment Period Is August 26, 2025 – September 12, 2025

The Rockwood School District is committed to providing a comprehensive benefits package to its Retirees even as healthcare costs continue to rise due to an increase in the frequency and severity of healthcare claims. This increase in healthcare costs is a scenario occurring across the market. Rockwood is committed to supporting our Retirees in this current healthcare climate the best we can.

2025 Benefit Plan Highlights

Open Enrollment at a Glance

August 26, 2025 to September 12, 2025 is the open enrollment window. All changes must be made by 4:30 p.m., September 12, 2025.

Adding Dependents

If you are adding a spouse or dependent(s) to your medical, dental or vision for the first time, please send a copy of their birth certificate(s) for your dependent(s) and/or marriage certificate for your spouse to the Benefits Office by October 12, 2025.

Programs to Improve Your Health

Rockwood offers many programs to support your physical and mental wellbeing, participation in some can even earn you incentive awards. For more information, turn to pages 21-30.

Earn Gift Cards!!

Rockwood wants Retirees to stay healthy and offers a $100 gift card for those who complete their annual preventative exam. See pages 26-27 for more information. You must be enrolled in the Cigna medical plan to participate.

Premiums & Benefits

There will be an increase to medical premiums, but dental and vision premiums are staying the same. See the rate chart on the back cover for more details.

Smart90

To fill **maintenance** medications and receive the discount, you have the option of filling through Express-Scripts home delivery or at a participating retail pharmacy, but it must be a 90-day supply. **If you fill a 30-day supply more than 2 times, you will be responsible for 100% of the cost of the medication.** When filling a 90-day supply you receive copay savings. For more information, turn to page 13.

Cigna and Express-Scripts Mobile Apps

Cigna and Express-Scripts no longer mail out a physical copy of your insurance card. You can download the mobile app on your phone to access a digital card. Then you always have your card with you. You also have the option to request a physical ID card. You can call Cigna at 1-800-244-6224 and Express-Scripts at 1-844-494-1052 for an ID card.

Message, Continued

Rockwood School District (RSD) is pleased to announce our 2025 benefits program, which is designed to help you stay healthy and feel secure. Offering a competitive benefits package is just one way we strive to provide our Retirees with a rewarding retirement. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions on One Rockwood or on Alight. Listed below are the Rockwood School District benefits available during open enrollment:

- Medical
- Dental
- Vision
- EAP

Who is Eligible?

All eligible retirees (those that retired with RSD and also retired with PSRS/PEERS on the same date) and their eligible dependents may participate in the Rockwood School District benefits program.

Generally, for the Rockwood School District benefits program, dependents are defined as:

- Dependent "child" up to age 26. (Child means the Retiree's natural child or adopted child and any other child as defined in the certificate of coverage)
- Your lawful spouse *(Please note, spouse cannot have an offer of coverage through their employer.)*

Benefits for You & Your Family

Do I Need to Log in During Open Enrollment?

Open enrollment will be conducted August 26, 2025 – September 12, 2025.

You do not need to log in if you want your benefits to remain the same.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Benefits Department within 30 days of the event. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

If you do not contact RSD within 30 days of a qualifying event, you will have to wait until the next Annual Open Enrollment period to make benefit changes unless you have another qualifying event. Visit rsdmo.org, click on Departments, Human Resources and Retiree Benefits for information on making your change request.

Contacts

Additional information regarding benefit plans can be found on rsdmo.org under Departments, Human Resources, Retiree Benefits page. Please contact the Benefits department to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFITS PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical	Cigna.	1-800-CIGNA24 (1-800-244-6224) Pre-Enrollment Hotline 1-800-401-4041	www.mycigna.com
Pharmacy	EXPRESS SCRIPTS®	1-844-494-1052	www.express-scripts.com
Medicare Advantage Plan *(For calls prior to 1/1/26)*	Anthem	1-833-848-8729 (First Impressions)	www.anthem.com
Medicare Advantage Plan *(For calls after 1/1/26)*	Anthem	1-833-848-8730 (Member Services)	www.anthem.com
Dental	DELTA DENTAL	1-800-335-8266	www.deltadentalmo.com
Vision	eyemed	1-866-939-3633	www.eyemed.com
Retiree Assistance Program (EAP)	PAS Personal Assistance Services	1-800-356-0845	www.MyPASEAP.com

All Retirees also have access to the USI Benefits Resource Center (BRC) to answer benefit/policy questions, assist you with eligibility and claim problems, provide claim appeals information, and explain allowable family status election changes (adding newborns, marriage, divorce, etc.).

Our Benefits Specialists can assist you Monday through Friday, 8am to 5pm EST & CST

USI

Call BRC toll free at 855-874-0829

2025-25 Rockwood School District
Retiree Group Insurance Rates
November 1, 2025 to October 31, 2026

Did you Know?

- Rockwood School District's medical, prescription and dental plans are self-insured. Rockwood School District is fully insured on its vision and EAP. When a plan is self-insured, the employer pays all the costs of health care, plus administrative fees. When a plan is fully-insured, the insurance company pays for the healthcare costs and the employer pays premiums to the insurance company.

- RSD's annual insurance fund is over **$30,000,000**.

- RSD has an Insurance Committee whose main charge is to make recommendations to the Board of Education, for their final decision, on funding, plan design, impact of any vendor changes, district's contribution increases, and the rate of the percent of dependent coverage.

Need Help?

Phone or email	Call or email RSD Benefit Staff during regular business hours between 8:00 a.m. – 4:30 p.m. Contact information may be found on page 53.
24/7	Contact the Cigna Pre-Enrollment Helpline at 1-800-401-4041. Representatives can help explain our medical plans and answer your medical plan questions.
By appointment	Make an appointment for a one-on-one phone consultation with one of our RSD Benefit Staff. Call 636-733-2043 to schedule your appointment.

Medicare Meeting: We have found a more affordable Medicare Advantage Plan through Anthem. Learn from our new Anthem rep about the RSD Medicare Advantage Plan. If you are already enrolled in Medicare, learn about this new plan. This meeting will take place September 3, 2025 at 9:00 a.m. at the Crestview Middle School Theater. More information was mailed to your home this summer.

Online Enrollment

Alight is our online enrollment tool. The site is accessible at worklife.alight.com/rockwoodschools and can be accessed 24 hours a day, 7 days a week.

After you log in, your username is your 10-digit employee ID preceded by RSD. Your password is your birth date without dashes. You will immediately be prompted to change your password.

Example: Username: RSD0000123456
Password: 01031973 (January 3, 1973)

Plan	Status	Start Date	Employer Cost	Your Cost
Medical Insurance Green PPO Retiree Only 12 Deductions/Year	• Complete	7/01/2025	$0.00	$657.18
Dental Insurance PPO Retiree Only 12 Deductions/Year	• Complete	7/01/2025	$0.00	$38.26
Vision Insurance Vision Care Retiree Only 12 Deductions/Year	• Complete	7/01/2025	$0.00	$4.78
Employee Assistance Program EAP - Retiree 12 Deductions/Year	• Complete	7/01/2025	$0.00	$1.65
Totals			**$0.00**	**$701.87**

Click on the Benefit to update

- Make sure you have the correct plan and coverage level selected.
- Make sure the correct people are assigned to each benefit.

You will know you are done when you can print a confirmation page. Be sure to review for accuracy.

Paper Enrollment Form

Retirees can also tear out and submit the enrollment form at the back of this book instead of using worklife.alight.com/rockwoodschools.

Medical Plans Under Age 65

Provider Network: **Cigna**
mycigna.com or 1-800-CIGNA24 (1-800-244-6224)
For help deciding which plan to enroll in, call Cigna's Pre-Enrollment Hotline 1-800-401-4041.

Pharmacy Administration: Express Scripts
express-scripts.com or 1-844-494-1052

TIP

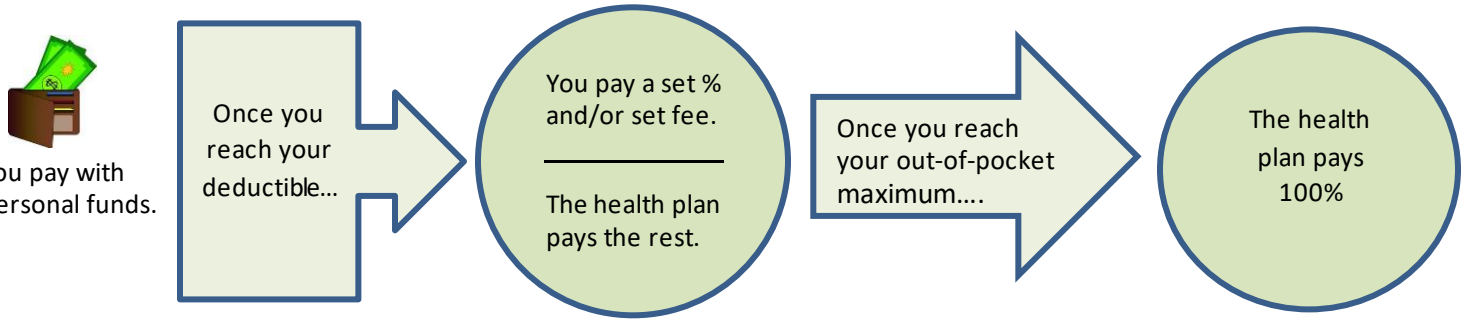
Look over your family's previous medical expenses to determine which plan will be best for you.

There are two medical plans to choose from:

1. Deluxe Green Plan

How your Deluxe Green Plan works

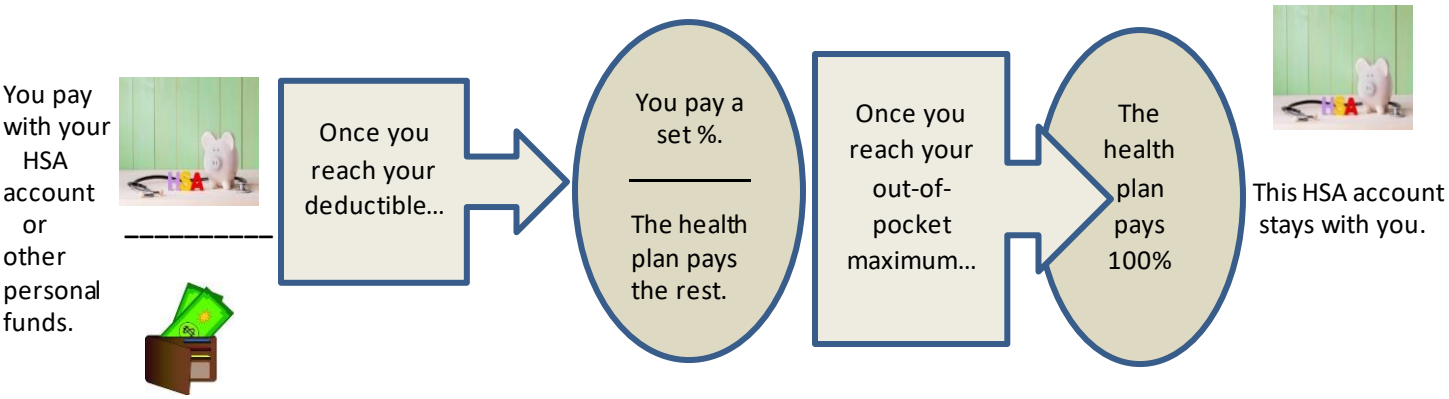
What's covered: Medical care, other health services. In-network preventive care services are covered at no additional cost to you.



2. High Deductible Tan Plan

How your Tan Plan works

What's covered: In-network preventive care services are covered at no additional cost to you.



Monthly Premiums

Green Plan

Retiree	$722.90
Retiree & Spouse	$1,548.78
Retiree & Child(ren)	$1,346.86
Retiree & Family	$2,172.90
Underage Dependent	$623.96
Spouse/Dep Only	$722.90

Tan Plan

Retiree	$590.58
Retiree & Spouse	$1,251.28
Retiree & Child(ren)	$1,089.76
Retiree & Family	$1,750.64
Underage Dependent	$499.18
Spouse/Dep Only	$590.58

For the Tan Plan, the deductible must be met before the prescription copay is applied.

Choosing the right medical plan is an important decision for you and your family. Take the time to review your family's past medical expenses and what expenses you are likely to incur during the upcoming plan year. Use this information to determine what kind of coverage is best for you and your family.

RSD offers you a choice between two medical plans: The Deluxe Green Plan and the High Deductible Tan Plan. Neither of these plans requires choosing a primary care physician or the need to obtain referrals for specialized care. Both plans provide 100% coverage for well care when using in-network providers. Both plans utilize the same network of physicians.

When you enroll in either the Green or Tan Plan, you will use your Cigna ID card for medical visits and your Express Scripts card at your pharmacy. Both Cigna and Express Scripts do not automatically mail out physical copies of your cards anymore unless you request them. You can download their mobile apps to your phone and your digital ID cards will be on their apps. You can also log into their websites or call them to request a physical card. Refer to page 4 for that information.

Medical Benefits Overview

Benefit Coverage	CIGNA Green Plan (Note: The Individual Deductible is embedded in the Family Deductible. See Page 52 for definition of embedded.)		CIGNA Tan Plan (HSA) (Note: The Individual Deductible is not embedded in the Family Deductible.)	
	In-Network Benefits (Open Access Plus Network)	Out-of-Network Benefits (see page 11 for more information)	In-Network Benefits (Open Access Plus Network)	Out-of-Network Benefits (see page 11 for more nformation)
Annual Deductible				
Individual	$1,000	$2,000	$3,000	$6,000
Family	$2,000	$4,000	$6,000	$12,000
Coinsurance	20%	40%	10%	40%
Maximum Out-of-Pocket (includes deductible)				
Individual	$4,000	$8,000	$4,000	$8,000
Family	$8,000	$16,000	$8,000	$16,000
Physician Office Visit				
Primary Care	$30 copay	40% After Deductible	10% After Deductible	40% After Deductible
Specialty Care	$50 copay	40% After Deductible	10% After Deductible	40% After Deductible
Virtual Care (Cigna Telehealth)	See Page 25 for Cost	Not Covered	See Page 25 for Cost	Not Covered
Preventive Care				
Adult Annual Exam	100%	40% After Deductible	100%	40% After Deductible
Well-Child Care	100%	40% After Deductible	100%	40% After Deductible
Maternity Care				
Prenatal and Postnatal Visit	Initial visit – PCP Copay All subsequent visits and Physicians Delivery Charge – Deductible then 20%	40% After Deductible	10% After Deductible	40% After Deductible
Diagnostic Services				
X-ray and Lab Tests	20% After Deductible	40% After Deductible	10% After Deductible	40% After Deductible
Complex Radiology	20% After Deductible	40% After Deductible	10% After Deductible	40% After Deductible
Urgent Care Facility	$50 copay	$50 copay	10% After Deductible	10% After Deductible
Emergency Room Facility Charges	$250 copay; waived if admitted	$250 copay; waived if admitted	10% After Deductible	10% After Deductible
Inpatient Facility Charges	$250 per admission copay; then 20%	40% After Deductible	10% After Deductible	40% After Deductible
Outpatient Facility and Surgical Charges	$150 per facility visit copay; then 20%	40% After Deductible	10% After Deductible	40% After Deductible
Therapy				
Occupational Therapy	$30 per visit copay	40% After Deductible	10% After Deductible	40% After Deductible
Physical Therapy	$30 per visit copay	40% After Deductible	10% After Deductible	40% After Deductible
Speech Therapy	$30 per visit copay	40% After Deductible	10% After Deductible	40% After Deductible

Benefit Coverage	CIGNA Green Plan (Note: The Individual Deductible is embedded in the Family Deductible. See Page 52 for definition of embedded.)		CIGNA Tan Plan (HSA) (Note: The Individual Deductible is not embedded in the Family Deductible.)	
	In-Network Benefits (Open Access Plus Network)	Out-of-Network Benefits (see page 11 for more information)	In-Network Benefits (Open Access Plus Network)	Out-of-Network Benefits (see page 11 for more nformation)
Mental Health				
Inpatient	$250 copay per admission; then 20%	40% After Deductible	10% After Deductible	40% After Deductible
Outpatient – Physician Office	$30 copay	40% After Deductible	10% After Deductible	40% After Deductible
Outpatient – All Other Services	20% After Deductible	40% After Deductible	10% After Deductible	40% After Deductible
Substance Abuse				
Inpatient	$250 copay per admission; then 20%	40% After Deductible	10% After Deductible	40% After Deductible
Outpatient – Physician Office	$30 copay	40% After Deductible	10% After Deductible	40% After Deductible
Outpatient – All Other Services	20% After Deductible	40% After Deductible	10% After Deductible	40% After Deductible
Other Services				
Chiropractic – Unlimited days First 26 visits per year without referral, additional visits if medically necessary.	$30 PCP / $50 Spec	40% After Deductible	10% After Deductible	40% After Deductible
Retail Pharmacy (30 Day Supply)*				
Generic	$10 copay	Not covered	$10 After Deductible	Not covered
Preferred	$35 copay	Not covered	$35 After Deductible	Not covered
Non-Preferred	$60 copay	Not covered	$60 After Deductible	Not covered
Preferred Specialty	10% with $100 Max	Not covered	10% AD with $100 Max	Not covered
Mail Order or Retail Pharmacy (90 Day Supply)				
Generic	$20 copay	Not covered	$20 After Deductible	Not covered
Preferred	$70 copay	Not covered	$70 After Deductible	Not covered
Non-Preferred	$120 copay	Not covered	$120 After Deductible	Not covered
Preferred Specialty [1-30 day supply]	10% with $100 Max for Retail Supply	Not covered	10% AD with $200 Max for Retail Supply	Not covered
Preferred Specialty [31-60 day supply]	10% with $200 Max for Retail Supply	Not covered	10% AD with $200 Max for Retail Supply	Not covered
Preferred Specialty [61-90 day supply]	10% with $300 Max for Home Delivery Supply	Not Covered	10% AD with $300 Max for Home Delivery	Not Covered

*After two 30-day supply of maintenance medications are filled, the third 30-day supply cost will be 100% the member's responsibility. It is less expensive to fill maintenance medications by using the Smart90 program (filling a 90-day supply). See page 13 for more information.

Note: Medical and Hospital care and costs for the infant child of a Dependent, unless the infant child is otherwise eligible, are not covered under this plan. Call Cigna at 1-800-244-6224 for more details.

For a detailed plan document, visit worklife.alight.com/rockwoodschools. Pre-certification for outpatient services will be required. Examples are (but not limited to): outpatient surgery, infusions, high-tech radiology, home health care/home infusions therapy, dialysis, durable medical equipment, prosthetic appliances, biofeedback, speech therapy, cosmetic or reconstructive procedures, infertility treatment, radiation therapy, sleep management, and transplants. Covered expenses incurred by an out-of-network provider will be reduced by 50% for charges if pre-certification isn't received prior to the date the testing or procedure is performed.

If you have questions, please call Cigna Customer Support at: 1-800-CIGNA24.

Staying In-Network

If you choose to see an out-of-network provider or pharmacy, you will still be able to use insurance; however, your costs will be *substantially* higher, and your deductible and out-of-pocket maximums will be higher. **If you choose to see an out-of-network provider, the amount could be higher than an in-network provider because the out-of-network provider probably won't give you the discounted rate that Cigna has negotiated like with the in-network provider.**

Your medical network is made of:

- Virtual care
- Convenience care (quick) clinics
- Physicians
- Facilities (urgent care, emergency room)
- Nurse practitioners
- Specialist
- Pharmacies
- Labs

TIP

When possible, choose virtual care or urgent care facilities over the emergency room to save time and money.

When you see an in-network provider, you will:

- Have lower health care costs for medical services and prescription drugs.
- Not have to handle obtaining any necessary pre-authorization. Your in-network provider will handle it before a procedure (such as surgery or imaging) on your behalf.
- **Not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary fees. There is a negotiated rate with an in-network provider but not with an out-of-network provider.**
- Not have to fill out forms to send to the insurance carrier in order to receive reimbursement: your in-network provider will handle this on your behalf.

How to find an in-network provider:

- Visit Cigna website at www.mycigna.com
  - ✓ If you haven't registered before, you will need to register. Once you are logged in, **click on Find Care & Costs. You will then be able to look up a doctor by type or name.**
- Call 1-800-CIGNA24 (1-800-244-6224)
- Check the myCigna mobile app

How to price medications:

- Visit Express-Scripts website at www.express-scripts.com
- If you haven't registered before, you will need to register. Once you are logged in:
  - ✓ To price medications, hover over prescriptions and then click on Price a Medication. Type in the medication you are wanting to price and the dose, if you have it, and enter your zip code. You will see different in-network locations to purchase it and how much it costs at each location.
  - ✓ To find an in-network pharmacy, hover over prescriptions and then click on Find a Pharmacy and enter your zip code.

Emergency Room vs. Urgent Care

More than 10 percent of all emergency room visits could have been better addressed in an urgent care facility or a doctor's office. Your health plan with Rockwood School District covers both emergency room and urgent care visits. If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

Emergency Room

The emergency room (ER) is equipped to handle **life-threatening injuries and illnesses** and other serious medical conditions. Patients are generally seen according to the seriousness of their conditions in relation to other patients.

Go to the nearest ER if you experience any of the following:

- Compound fractures
- Shortness of breath
- Broken bones
- Poisoning
- Seizures
- Chest pain or difficulty breathing
- Uncontrollable bleeding

Cost with CIGNA Medical OAP (Green Plan): $250 copay; waived if admitted

Cost with CIGNA Medical OAP HSA (Tan Plan): 10% After Deductible is met

Urgent Care

Urgent care centers also offer after-hour care. Unlike emergency rooms, they are not equipped to handle life-threatening situations. Rather, they are designed to address **conditions where delaying treatment could cause serious problems or discomfort.**

These conditions can be treated in an urgent care center:

- Cuts that require stitches
- Diagnostic tests (x-rays, labs)
- Ear infections
- Fever or the flu
- Sprains or strains
- Vomiting, diarrhea or dehydration
- Urinary tract infections

Cost with CIGNA Medical OAP (Green Plan): $50 copay

Cost with CIGNA Medical OAP HSA (Tan Plan): 10% After Deductible is met

Choosing the appropriate place of care not only ensures prompt and adequate medical attention, it also helps reduce unnecessary medical expenses. Although urgent care centers are usually more cost-effective, they are not a substitute for emergency care.

Tips for Saving on Your Health Plan Year Round

More Expensive Options		Less Expensive Options
Out-of-network doctors and pharmacies	Vs	In-network doctors and pharmacies
Brand name medications	Vs	Generic medications
Emergency room, average cost $1,523 (for non-emergencies)	Vs	Urgent Care, average cost $131 Convenience clinic, average cost $76 (for non-emergencies)
Hospital lab, average cost $48	Vs	Quest or Lab Corp, average cost $9
Hospital radiology CT, average cost $1,198	Vs	Independent radiology center CT, average cost $591
Hospital radiology MRI, average cost $1,676	Vs	Independent radiology center MRI, average cost $706
Outpatient surgery in a hospital, average cost $2,821	Vs	Outpatient surgery in a surgery center, average cost $1,438

Please note that every health plan is different.
You should check your plan documents to determine which tips apply to your plan.

Prescription Medication Coverage

Our medical plans include prescription drug coverage through **Express Scripts.** The cost of each prescription is determined by the tier it falls under. The three tiers are Generic, Preferred, and Non-Preferred. You can find in-network pharmacies and a list of covered prescriptions at express-scripts.com or 1-844-494-1052. Whenever possible, generics provide the most economical way to fill your prescriptions. See page 11 for more details on how to price a medication.

Smart90 Program: To fill **maintenance** medications and receive the discount, you have the option of filling through home delivery from Express Scripts Pharmacy or at a participating retail pharmacy but it must be a 90-day supply. When filling a 90-day supply you receive copay savings, please refer to the table below. You will be allowed to fill a 30-day supply of your maintenance medication two times; after that, you will be responsible for 100% cost of the medication.

You can access your ID card on the mobile app. If you still want a physical copy of your ID card, you can call Express-Scripts to get a card.

Generic Drugs

To get more out of your health care plan, choose generic drugs when possible. Generic drugs are the chemical equivalent of their more expensive brand name drug counterparts. Even if your doctor prescribes a brand name drug, you can always ask for the generic equivalent.

Preferred Drugs

Preferred brand drugs are prescriptions that your pharmacy benefit plan has selected as the most effective and cost efficient to treat certain conditions or illnesses. These brand name drugs are often more expensive than their generic counterpart.

Non-Preferred Drugs

Non-preferred brand drugs treat conditions or illnesses that can also be treated by a preferred brand or generic prescription. These drugs typically have a higher copayment.

TIP

Use the Express Scripts mobile app to price medication while talking to your doctor.

Pharmacy Benefits	30-Day Supply*	90-Day Supply Retail	90-Day Supply Home Delivery
Generic Copay	$10	$20	$20
Preferred Copay	$35	$70	$70
Non-Preferred Copay	$60	$120	$120
Specialty Medications	1-30 day supply 10% with $100 max	31-60 day supply 10% with $200 max	61-90 day supply 10% with $300 max

For the Green Plan, the deductible does not apply.

For the Tan Plan, the deductible must be met before the copay is applied.

This means when you are on the Tan Plan you pay full cost for your prescriptions until you reach your deductible. While on the Green Plan, you will pay copays from day one.

***You can fill 2 30-day supply of maintenance medications and after the second fill, you will pay 100% of the cost.** It is less expensive to fill maintenance medications by using the Smart90 program (filing a 90-day supply).

Medicare Advantage Plan

We have a new Medicare Advantage Plan for RSD Retirees. We did a search for a more affordable plan that covered at least what your current provider covers or better. Anthem came out as the best option for our retirees. We sent letters to your home with information on how to enroll in one of their plans. If you have any questions, please call:

FIRST IMPRESSIONS – 1-833-848-8729 (For all inquiries prior to 1/1/26) – (General plan questions, provider in/out of network, benefits, costs, etc.)
Retirees can call in prior to the 1/1 effective date to ask any questions they may have about the upcoming plan. Agents will be trained on the plan and will be able to answer any general questions.

MEMBER SERVICES – 1-833-848-8730 – ACTIVE 1/1/26 – (All inquiries after 1/1/26)

Once a retiree becomes eligible for Medicare, the Cigna medical plans pay secondary to Medicare Part B, so it is important the retiree enroll in Part B. Because of this, the district partners with Anthem to provide alternative insurance options that closely mirror the plan design of the Rockwood plan at a much-reduced premium**.**

There are two plans to choose from, PPO Plan 15PH (High) plan and PPO Plan 20PD (Low) plan. Please see the Overview of Coverage and Premiums on the next page for more information or contact Anthem for a summary plan document.

To enroll in one of the Anthem Advantage Plans for RSD Retirees, you will need to enroll in Medicare A and B. This plan includes Part D coverage, so you cannot enroll in a separate Part D plan. You will waive your Cigna coverage. For this reason, you will need to enroll and contact the RSD Benefits office to waive your Cigna coverage. You can start this process 3 months prior to your 65th birthday.

You don't have to enroll in the Anthem Advantage plan, it is just one of the many options you have when you are 65 or older. Do your homework; look at premiums, deductibles, office visit copays, prescriptions costs, etc. when making your decision.

Once you are enrolled in Medicare, you can still stay on Rockwood's Dental and Vision plans if you choose to.

Medicare Advantage Plan – Plan Option Highlights

For more detail, refer to the Summary Plan Description on the Anthem website, www.anthem.com.

2026 Plan Name	Anthem PPO High Plan (15PH)	Anthem PPO Low Plan (20PD)
Eligibility	Enrolled in Medicare Part A & B and live within the service area	Enrolled in Medicare Part A & B and live within the service area
Network	Anthem Medicare Preferred PPO	Anthem Medicare Preferred PPO
Medical Benefits	The PPO Out-of-Network benefits are the same as In-Network benefits	The PPO Out-of-Network benefits are the same as In-Network benefits
2026 Monthly Premium	$221.74	$118.08
Annual Medical Deductible**	$0	$500
Out of Pocket Max*	$4,150	$4,150
Inpatient (1-5 days per admission)	$150 copay per admission	$200 copay per admission
Outpatient Surgery	$200 copay per visit	$150 copay per visit
PCP/Specialist	$15/$25	$20/$30
Video Doctor Visits (LiveHealth Online)	$0 copay for video doctor visits using LiveHealth Online (LHO)	$0 copay for video doctor visits using LiveHealth Online (LHO)
Annual Wellness Visit	$0 copay per visit	$0 copay per visit
Lab	$0 copay	$0 copay
X-Ray	$0 copay	$0 copay
Diagnostic Radiology	20% coinsurance	$120 copay
Diagnostic Testing & Procedures	20% coinsurance	$120 copay
Urgent Care	$25 copay per visit	$50 copay per visit
ER	$50 copay per visit	$120 copay per visit
Ambulance	$100 copay per one-way trip	$120 copay per one-way trip
RX (standard)	$10/$35/$55/25%	$10/$35/$55/25%
90-Day RX	2x copay (Tier 4-NA)	2x copay (Tier 4-NA)
Vision Eyewear Reimbursement	$100 every **calendar year** Blue View Vision	$200 every **calendar year** Blue View Vision
Hearing Aid Reimbursement	$500 every **calendar year** Hearing Care Solutions	$2,500 every **calendar year** Hearing Care Solutions
Medicare Community Resource	$0 cost to member EAP (Employee Assistance Program)	$0 cost to member EAP (Employee Assistance Program)
Silver Sneakers	Free Fitness Program	Free Fitness Program
Meals	**Covered up to 14 meals per qualifying event, allows up to four events each year (56 meals in total)**	**Covered up to 14 meals per qualifying event, allows up to four events each year (56 meals in total)**
Dental (In-Network)	Routine Dental Services, $1,000 max benefit each year, Preventive Services: $0 deductible / 0% coinsurance Basic Services: $0 deductible / 20% coinsurance, Major Services: $0 deductible / 50% coinsurance	
Dental (Out-of-Network)	Routine Dental Services, $1,000 max benefit each year, Preventive Services: $0 deductible / 20% coinsurance Basic Services: $0 deductible / 40% coinsurance, Major Services: $0 deductible / 50% coinsurance	
Annual 2025 Cost	$2,660.88	$1,416.96

**** Does Not apply to the PPO deductible:**
$0 preventive care, including annual physicals, PCP services; specialist services; routine x-rays, labs and diagnostic test/procedures; routine eye and hearing exams; medical supplies; ambulance & emergency room.

*Does Not Include Copays or Rx Copays

NOTE: Both plan options provide benefits and care in every state. Retirees can visit any doctor who accepts Medicare, in or out of the plan's network, anywhere in the nation.

Dental Insurance

Dental Network and Administration: **Delta Dental**
1-800-335-8266 or DeltaDentalMO.com

TIP

If you have services performed, be aware of your deductible and out-of-pocket maximum and when these "start over."

If your dentist recommends services other than a preventive cleaning, ensure you ask for and receive a pre-treatment estimate *before the work is performed.* This will avoid any misunderstanding of Delta Dental benefit payment amounts.

Delta Dental has a unique two-tiered system of participating providers: **Delta Dental PPO and Delta Dental Premier.** These networks are critical in the delivery of quality care while maximizing cost savings for you and Rockwood School District.

- Delta Dental's PPO Network offers access to over 113,000 dentists in over 380,000 locations.
- Delta Dental's Premier Network offers access to over 150,000 dentists in over 440,000 locations.

You will receive $2,000 maximum for in-network Orthodontia services provided by a PPO provider.

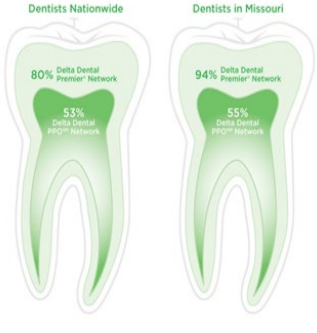
Make sure you understand that if you choose an out-of-network dentist, they don't have to charge you the negotiated amount that Delta Dental has negotiated for us with the in-network dentists. So even though the benefit summary on the following page says 100% covered, that is 100% of the negotiated rate for an in-network dentist.

Dental PPO Dentists	Delta Dental Premier Dentists	Non-Participating Dentists
• Delta Dental Contracted Provider • Deepest Discounted Fees • No Balance Billing • No Claim Forms • Direct Dentist Reimbursement	• Delta Dental Contracted Provider • Discounted Fees • No Balance Billing • No Claim Forms • Direct Dentist Reimbursement	• Not Under Contract with Delta Dental • **No Discounted Fees** • **Balance Billing is Possible** • Some Dentists May Not File Claims • Patient Reimburses Dentist

Dental	Total Retiree Cost
Retiree Only	$38.26
Retiree + Spouse	$75.42
Retiree + Child(ren)	$83.38
Retiree + Family	$120.62

DELTA DENTAL

Dental Benefits Summary

Rockwood School District Group # 9127	Delta Dental PPO℠ Network	Delta Dental Premier® Network	Out-of-Network
	Based on applicable PPO Maximum Plan Allowance - No balance billing	Based on applicable Premier Maximum Plan Allowance - No balance billing	Based on applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible
Preventive Services • Oral examinations (evaluations) • Bitewing and periapical x-rays • Full-mouth x-rays • Prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits) • Topical fluoride application for children under age 19 • Sealants for children under age 19 • Brush biopsy	**100%**	**100%**	**100%**
Basic Services • Space maintainers for children under age 16 • Emergency palliative treatment • Fillings • Periodontics • Endodontics • Oral surgery including simple and surgical extractions. **Extractions of bony impacted wisdom teeth are not covered under dental but covered under the medical plan.** • General anesthesia	**90%**	**80%**	**80%**
Major Services • Bridges and dentures • Crowns, jackets, labial veneers, inlays and onlay • Implants and bone grafts	**90%**	**80%**	**80%**
Orthodontia • For dependent children under age 19	**80% up to $2,000**	**50% up to $1,500**	**50% up to $1,500**
Calendar Year Deductible (Applied to Basic, Major and Orthodontic Services)	**$50 individual 2X family**	**$50 individual 2X family**	**$50 individual 2X family**
Annual Maximum (Applied to Preventive, Basic and Major)	**$1,000**	**$1,000**	**$1,000**
Dependent Age Limit: 26			
Added Features Included **MAX*Advantage***: Charges for exams, cleanings, x-rays, and fluoride treatments do not apply towards your annual maximum. ***Healthy Smiles, Healthy Lives***: Two additional cleanings are covered per benefit period for patients who are pregnant, diabetic, have a suppressed immune system, or have a history of periodontal therapy. To be eligible for the additional benefits, you must submit a completed Self-Report form which can be obtained at www.deltadentalmo.com under the Member section, or by contacting customer service.			

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Document will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions.

Vision Insurance

Vision Insurance Carrier: **EyeMed**
1-866-939-3633 or eyemed.com

Eyesight is critical to your overall health. Did you know that a regular eye exam can detect high cholesterol or even a brain tumor? Retirees can enroll in Retiree only, Retiree + one dependent, or Retiree + two or more dependents.

TIP

For those on the green plan only: Cigna medical plans cover one annual eye exam at 100%. Make sure your provider codes your eye exam as preventive and use your Cigna medical ID. For those on the tan plan, you must meet your deductible first.

When you schedule your appointment, verify your provider is in the EyeMed's **Advantage Network**. Providers can be found at eyemed.com, on the mobile app or by calling customer service at the above phone number.

Many Retirees find ID cards useful, however ID cards are not needed to obtain services from an in-network provider.

To use your EyeMed vision insurance:

1. Present your ID card, or
2. Use the EyeMed mobile app ID card, or
3. Simply let your provider know the name and date of birth of the person with the appointment along with the Group # (1017708) for the provider to access coverage.

Vision	Total Retiree Cost
Retiree Only	$4.78
Retiree + 1	$8.52
Retiree + 2 or more	$12.76

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

PDF-2004-M-377

Vision Benefits Summary

40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses*

Find an eye doctor

(Advantage Network)

- 888.203.7437
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.

SUMMARY OF BENEFITS

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	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up – Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $31
Bifocal	$10 copay	Up to $51
Trifocal	$10 copay	Up to $64
Lenticular	$10 copay	Up to $80
Progressive – Standard	$60 copay	Up to $64
Progressive – Premium	$60 copay; 30% off retail price less $110 allowance	Up to $64
LENS OPTIONS		
Anti Reflective Coating – Standard	$40	Not covered
Anti Reflective Coating – Premium	20% off retail price	Not covered
Photochromic – Non-Glass	30% off retail price	Not covered
Polycarbonate – Standard	$35	Not covered
Polycarbonate – Standard < 19 years of age	$0 copay	Up to $5
Scratch Coating – Standard Plastic	$0 copay	Up to $5
Tint – Solid and Gradient	$0 copay	Up to $5
UV Treatment	$0 copay	Up to $5
All Other Lens Options	30% off retail price	Not covered
CONTACT LENSES		
Contacts – Conventional	$0 copay; 15% off balance over $125 allowance	Up to $125
Contacts – Disposable	$0 copay; 100% of balance over $125 allowance	Up to $125
Contacts – Medically Necessary	$0 copay; paid in full	Up to $250
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	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
FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every plan year	Once every plan year
Contact Lenses	Once every plan year	Once every plan year

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

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Health Savings Account

HSA

A health savings account allows you to set aside money on a pre-tax basis to pay for qualified expenses, such as doctor visits, prescriptions, braces, or even Lasik eye surgery, with tax-free dollars.

There is no use it or lose it rule with HSAs. Any remaining balance at the end of the year will roll over into the next year.

TIP

Keep all receipts from HSA expenses and associated documentation to prove HSA funds were used for qualified medical expenses.

One of the best parts of the HSA is its triple-tax advantage: tax-free deductions when you contribute to your account, tax-free investment earnings, and tax-free withdrawals for qualified medical expenses.

When you enroll in the High Deductible Tan Plan, you will receive a card linked to your account to pay for qualified expenses. You may be penalized or taxed if you use your HSA funds to pay for ineligible expenses. Qualified expenses include prescriptions, contact lens fitting, orthodontia, acupuncture, artificial teeth, eye glasses, or other expenses that apply towards your deductible. A full list of qualified expenses can be found on the IRS website (IRS Publication 502).

Eligibility

- You are enrolled in the **High Deductible Tan Plan;** and
- You are not covered under another medical plan such as Medicare**, Tricare or a spouse's medical plan (not a HDHP) which provides similar coverage; and
- You cannot be claimed as a dependent on another person's insurance policy or tax return
- You may use the money in your HSA to pay for qualified expenses for you, your spouse and dependents, even if they are not enrolled in your plan.

2026 IRS CALENDAR YEAR CONTRIBUTION LIMITS

Individual	Family	Age 55+ Catch Up
$4,400*	$8,750*	$1,000

*Check with your Tax advisor on when to stop contributing to your HSA prior to enrolling in Medicare.

Programs

Livongo Diabetes Program Key Features:

- For members diagnosed with type 1 or type 2 diabetes.
- More than a standard meter – The Livongo connected blood glucose meter uploads readings and provides real-time tips, making log books a thing of the past.
- Get as many test strips and lancets as you need shipped to your door, with no hidden costs.
- Coaches are Certified Diabetes Educators who can assist you with nutrition and lifestyle changes.



Livongo Hypertension Program Key Features:

- Easy remote monitoring via wireless-connected blood pressure cuff.
- Intuitive mobile experience to track progress and receive personalized, clinically-grounded coaching and educational content.
- Tips to help you stay on track – Receive useful information and reminders to manage your blood pressure and feel your best.
- Coaching in nutrition and weight, stress and blood pressure management – Licensed professionals provide live coaching, virtual care, and 24/7 digital alerts.



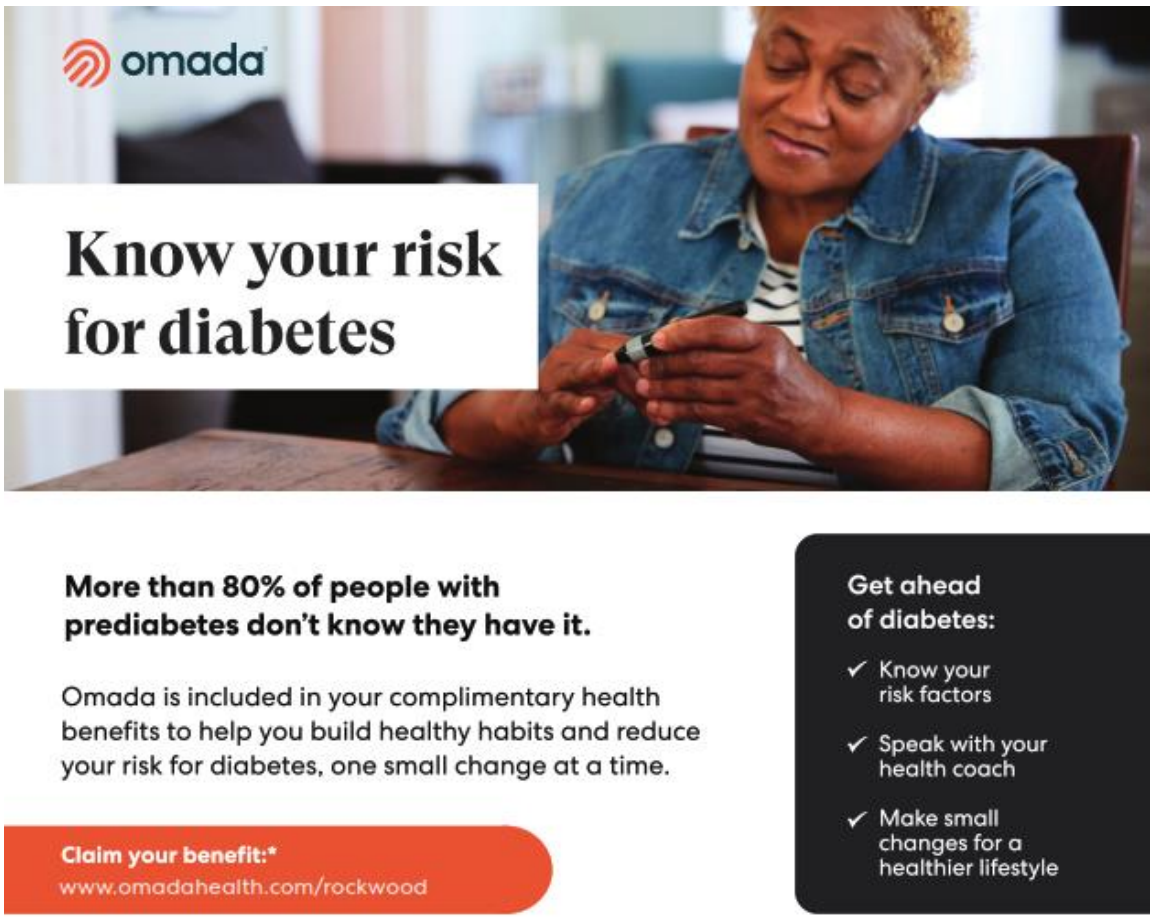
If you qualify for one or both of the Livongo programs, you will be contacted by Livongo.

Insulin Help - Patient Assurance Protection Program Key Features:

- We have partnered with Express Scripts to bring down the cost of preferred insulin products for you and your family members living with diabetes.
- Eligible members will pay no more than $25 per 30-day supply. That can mean more affordable access to insulin, and more money in your pocket.
- There is no additional charge to RSD or to you!
- Contact Express Scripts, (844) 494-1052, for more information or details about participating medications.

The Cigna Diabetes Program in Collaboration with Omada

- If you are at risk for diabetes or heart disease, you may be eligible for Omada, an intensive, virtual program that coaches you in making healthy lifestyle changes that last. It is a preventive care service that is covered at 100%.
- Participation in the program includes a virtual coach, an online community for support and encouragement, an app to track food, weight and physical activity, and a "smart" scale that automatically sends data to the app.
- Visit myCigna.com – Wellness & Incentives or call 1-800-CIGNA24 for more information.



Employee Assistance Program (EAP)

Provider: **Personal Assistance Service (PAS)**
MyPASEAP.com or 1-800-356-0845

All RSD Retirees are eligible to enroll when they first retire. EAP coverage must be elected for the entire plan year. The premium for EAP is $1.65 per month. If EAP enrollment is not elected at the initial offer of coverage, the retiree cannot elect EAP at future Open Enrollments.

All services are free and confidential. To access this benefit, contact PAS at 1-800-356-0845 or visit MyPASEAP.com.

The District Code is: Rockwood SD

What types of problems can the EAP help me resolve?
The EAP is an excellent resource to find help for personal, family, and work/life balance concerns. Some of the areas covered by the EAP include:

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

Personal Assistance Services

New member portal

New URL: www.mypaseap.com

Your organization code is:

Rockwood SD

Please create a user ID and password to access the portal, entering your name, email and phone number, either personal or work. Any eligible family member may have their own account.

Features of the new member portal include:

- Personalized Member Dashboard with easy access to PAS digital engagement tools
- Quick connect bar to access PAS services from any device using chat, voice and email
- Care Navigator needs assessment with personalized recommendations to PAS resources and services
- Easy access to all PAS resources including calculators, worksheets and micro trainings
- Ability to pin articles and resources for future reference

For questions about the member portal, please email us at: pasadmin@paseap.com

Virtual Care

Try Cigna's virtual care options. Find out more at mycigna.com

Cigna's Nurse Help Line

Need help deciding about your health or medical treatment? Call 1-800-244-6224 to get immediate support and advice from a Registered Nurse. This service is available 24/7 and free to those enrolled in Cigna medical coverage.

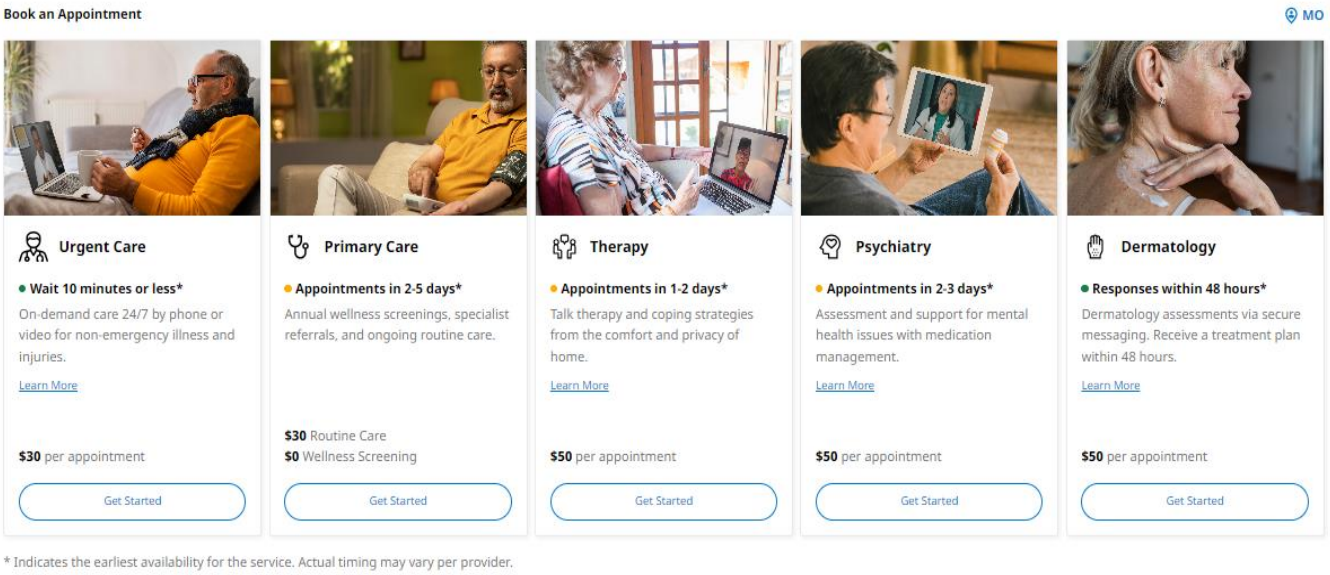
Talk to a board-certified doctor 24/7

The cost of Virtual Care depends on the type of provider seen. See charts below for the green plan and tan plan.

Virtual care prices are not always flat rates and are subject to change. The most current cost of care will be shown before making an appointment. *Visit mycigna.com or call 1-888-726-3171 for your cost. Prices subject to change in 2026.

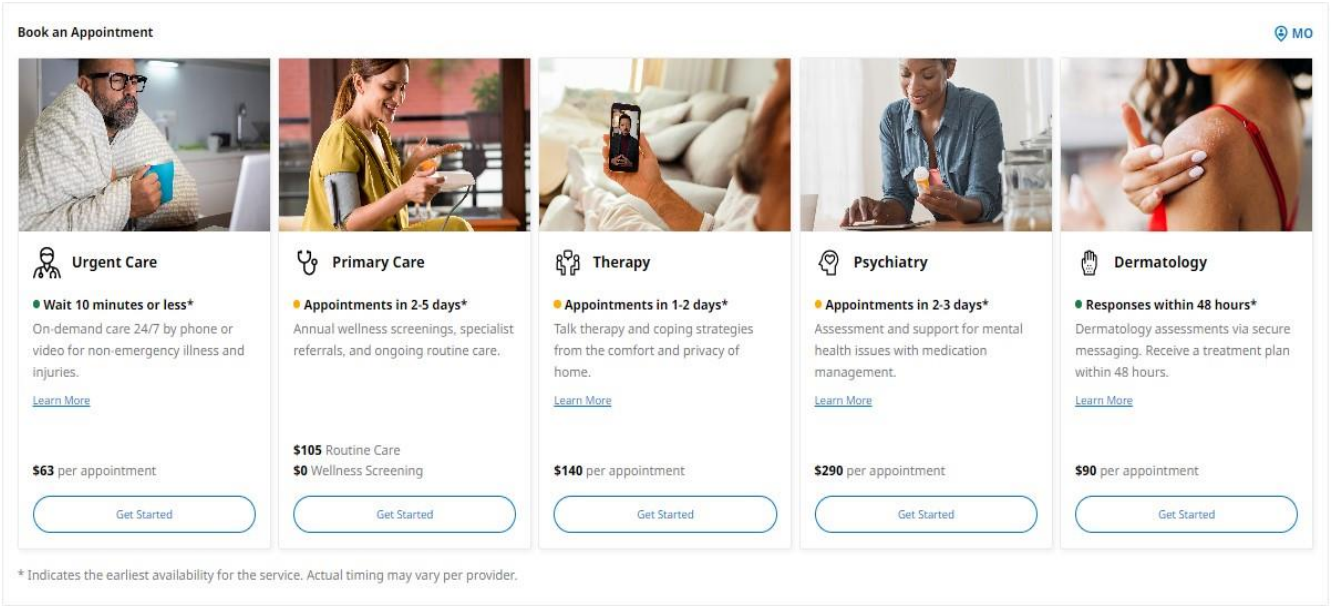
Must access MDLive through mycigna.com or MDLiveforCigna.com to receive plan rates.

Virtual Care prices for those on the Green Plan*



* Indicates the earliest availability for the service. Actual timing may vary per provider.

Virtual Care Prices for those on Tan Plan*



* Indicates the earliest availability for the service. Actual timing may vary per provider.

Retiree Wellness

2025 – 2026 Incentives*

Retirees Earn $300 & Spouses Earn $50 by Improving Your Health!

Your health is a priority! Earn $300 in incentives, redeemable in gift cards, just by taking steps to maintain or improve your wellbeing.

You MUST complete the two goals below in order to REDEEM your incentive dollars for gift cards on myCigna.com. **You will not be able to see any other completed goals until you complete these two:**

-  Personal Health Assessment – Log into myCigna.com to complete, hover your mouse Over Wellness and click on My Health Assessment.
-  Complete your annual wellness exam with your primary care doctor. Annual wellness exams are covered at 100% under all RSD Cigna medical plans.

Visit the next page to see a complete list of goals in addition to the two listed above.

Get started earning incentives as soon as November 1, 2025 by visiting the Wellness page on myCigna.com and completing your Personal Health Assessment.

Incentive rewards expire 90 days after the plan year ends.

If you leave Rockwood, you have 90 days after your termination date to redeem your incentives.

Spouses on your Rockwood plan can earn $50 (total) for completing the health assessment and their annual wellness visit.

For questions, contact our On-Site Cigna Rep/Wellness Coordinator at 636-733-2062.

*Incentive rewards are available to Retirees covered by the Cigna medical plan through RSD. Incentive points are redeemable as gift cards through myCigna.com. InComm is the vendor that Cigna partners with for the gift card awards. Gift cards are taxable income. Incentive points must be redeemed within 90 days of the end of the plan year. If you're unable to meet a goal's objectives, you may still be able to earn the award by completing an alternate activity. Visit myCigna.com and select a goal to see its alternate activities.

2025-26 Incentive Goals
Complete between November 1, 2025 - October 31, 2026

Goal	Details	Retiree Award Amount Max $300	Spouse Award Amount Max $50
Health Assessment	Complete a Personalized Health Assessment on myCigna.com	$0	$0
Annual Preventive Exam	Complete your annual preventive exam with your primary care provider (your doctor must code the visit as preventive for the goal to be posted and rewarded)	$100	$50
You must complete the above 2 goals to redeem your incentives. You may complete the goals in any order but, you will not be able to see the "Redeem" button on myCigna.com until the above 2 goals are completed.			
Biometric screening	Complete a biometric health screening at an on-site biometric event, a Quest patient service center or with the health screening form completed by your provider	$50	N/A
Cancer screening	Complete a cancer screening (prostate, breast, cervical, colonoscopy, skin*) *the skin cancer screening claim has to have the code DXCD Z12.83 for the goal to be posted and rewarded.	$50 each	N/A
Achieve a health goal to overcome a chronic health problem	Work with a trained health coach to identify and work towards a personal goal related to a serious health problem* Call a health coach at 1-855-246-1873 *Included health conditions: Asthma, Chronic Obstructive Pulmonary Disorder (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Depression, Diabetes, Low Back Pain, Osteoarthritis, Peripheral Artery Disease (PAD)	$75	N/A
Get help understanding medical treatment options	Discuss treatment options for back pain, hip/knee osteoarthritis, heart problems, benign uterine conditions, prostate cancer or breast cancer and make an informed choice with your health coach Call a health coach at 1-800-244-6224	$75	N/A
Manage Stress &/or Weight Loss Participate in the Lifestyle Management Program	Complete the Manage Stress or Lose Weight coaching program over the phone through Cigna Call a health coach at 1-855-246-1873	$25 each	N/A
Complete the Omada Program	Complete the 16-week Omada program (Incentivized once per lifetime)	$50	N/A
Flu shot	Get your flu shot using your Cigna insurance. Self-report date completed on myCigna.com.	$10	N/A
Preventive dental cleaning	Get a preventive dental cleaning (2x per year). Self-report dates completed on myCigna.com.	$25 each maximum of $50	N/A
Healthy Pregnancies, Healthy Babies	Participate in and complete the Healthy Pregnancies/Healthy Babies program, while pregnant, for help staying healthy during and after pregnancy	$100-enrolled in 1st trimester $50-enrolled in 2nd trimester	N/A

Flu Vaccination Clinic

Influenza (also known as the flu) is a serious disease that can lead to hospitalization and even death. Every flu season is different, and influenza infections can affect people differently. While millions of people get the flu every year, hundreds of thousands of people are hospitalized, and tens of thousands die from flu-related causes every year. Even healthy people can get very sick from the flu and spread it to others. (cdc.gov/flu)

To help our employees, retirees and students stay well, RSD provides on-site flu vaccination clinics. These clinics are staffed by the Visiting Nurses Association (VNA).

Here's what you need to know about getting your flu vaccination on-site:

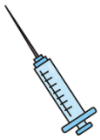
1. **Bring your insurance card.** Flu vaccinations are required by the ACA (Affordable Care Act) to be paid by insurance plans at no cost to the individual. If you have Cigna insurance or another insurance accepted by VNA, you will have no out of pocket expense as long as you bring your insurance card.
    - If you have a spouse or dependent on Cigna coverage through RSD and want them to be vaccinated at an RSD clinic, please bring their insurance ID card.

2. Insurance accepted by VNA at Rockwood flu clinics: Aetna (no EPS's), Anthem-Blue Cross and Blue Shield (No EPO's), Cigna (No EPO's), Coventry, HealthLink, Humana, Medica, TRICARE, United HealthCare (including AllSavers, GoldenRule, UMR, & GEHA); Medicare Plans: Medicare Part B, Aetna (HMO/PPO), Anthem/BCBS Advantage (HMO/PPO), Essence; Medicare Advantage Plans – PPO Only (no HMO): Cigna, Coventry, Humana, UHC (including PPO AARP); Missouri Medicaid (18 and Younger Only): Homestate Health, Missouri Care, United HealthCare Community Plans, Healthy Blue, Ambetter, MO Healthnet. ****VNA cannot accept Medicaid plans for those over the age of 18.

3. Students and community members may also receive a flu vaccination at an RSD flu clinic. These individuals can either pay using their medical insurance or by cash.

4. Individuals 6 months of age and older can receive a vaccination at our RSD on-site clinics. A signed consent form (by a parent or legal guardian) must be provided in order to vaccinate anyone 17 years old or younger.

5. If you miss an RSD flu clinic, don't worry! You can still get a flu vaccination at your primary care provider's office or at a convenience care clinic like Walgreens, CVS and Walmart. They will need a pediatrician prescription for kids 12 and under. Bring your insurance card and there will be no cost to you!



Schedule of RSD Flu Vaccination Clinics can be found on rsdmo.org/departments/human-resources/retirees/wellness

2025 RSD Flu Vaccine Clinics

DATE	LOCATION	TIME
9/17/25	Kellison Elementary School	3:30PM-5:30PM
9/18/25	Fenton Bus Garage	12:30PM-2:30PM
9/18/25	Uthoff Valley Elementary School	3:30PM-5:30PM
9/19/25	Chesterfield Elementary School	8:00AM-10:00AM
9/19/25	Westridge Elementary School	11:00AM-1:30PM
9/22/25	Clarkson Valley Early Childhood Center	10:30AM-12:30PM
9/22/25	Crestview Middle School	1:30PM-3:45PM
9/23/25	Geggie Elementary School	3:00PM-5:30PM
9/23/25	Administrative Center (Central Office)	1:00PM-2:00PM
9/24/25	Fairway Elementary School	3:00PM-5:30PM
9/29/25	Eureka Elementary School	3:00PM-4:30PM
9/29/25	Vandover Early Childhood Center	12:00PM-2:00PM
9/29/25	Bowles Elementary School	11:30AM-2:00PM
9/30/25	Marquette High School	8:00AM-11:30AM
10/1/25	Rockwood Summit High School	3:00PM-5:30PM
10/2/25	Babler Elementary School	2:00PM-5:00PM
10/3/25	Ellisville Elementary School	7:00AM-9:00AM
10/7/25	Eureka Early Childhood Center	11:30AM-1:30PM
10/7/25	Rockwood School Middle School	2:30PM-5:30PM
10/9/25	Administrative Annex	9:00AM-11:30PM
10/10/25	Woerther Elementary School	7:30AM-10:00AM
10/10/25	Wildwood Middle School	11:00AM-2:00PM
10/13/25	**Pond Elementary**/Facilities/Child Nutrition/Pond Bus Lot	10:30AM-1:00PM
10/13/25	LaSalle Middle School	2:00PM-5:30PM
10/14/25	Stanton Elementary School	3:00PM-5:00PM
10/15/25	Blevins Elementary School	3:00PM-6:00PM
10/16/25	Ridge Meadows Elementary School	4:00PM-6:30PM
10/16/25	Eureka High School	3:00PM-6:00PM
10/17/25	Ballwin Elementary School	3:30PM-6:00PM
10/21/25	Kehrs Mill Elementary School	11:30AM-2:30PM
10/21/25	Green Pines Elementary School	3:30PM-6:00PM
10/22/25	Lafayette High School	3:30PM-6:00PM
10/23/25	Selvidge Middle School	1:00PM-3:30PM
10/24/25	Wildhorse Elementary School	2:00PM-4:30PM
10/27/25	Center for Creative Learning (CCL)	7:00AM-8:45AM
10/28/25	Rockwood Valley Middle School	2:30PM-4:30PM

Biometric Screenings and Health Fair

Your cholesterol, blood pressure, blood sugar and body mass index numbers are key indicators of your risk for serious illness. If you know your numbers you can make changes to improve your health and reduce your risk of developing heart disease, diabetes and other serious illnesses. We want to make it convenient and rewarding to know your numbers.

Complete your Preventive Annual Wellness Exam with your Primary Care Provider ($100 incentive)

In-network preventive care is covered at 100%, at no cost to you, not even for the labs!

Your in-network provider will share data with Cigna to electronically complete your incentive.

Easy ways to complete your biometric screening ($50 incentive-see page 27 for more information)

At an onsite event: Rockwood hosts onsite biometric screening events throughout the year. Complete your biometric screening onsite and the data is shared with Cigna electronically to complete your incentive.

At a Quest Lab location: Make an appointment to complete your biometric screening at a Quest location. The lab will send data electronically to Cigna in order to complete your incentive.

By your doctor: Your own doctor can perform the screening as part of your annual wellness visit. Ask your doctor to complete the wellness screening form, found on myCigna.com, and submit it to Cigna to complete your incentive.

Virtually: You can schedule a virtual preventive visit with MDLIVE that includes a biometric screening. After this appointment is completed, information will be sent electronically to Cigna in order to complete your incentive.

RSD Health Fair:

We are moving our health fair to August moving forward. In 2025, it will be August 15 from 12:30-5PM.

Come and learn more about your health and wellbeing and leave with peace of mind. We will have games, **Raffle off prizes**, snacks, photo-booth & more fun activities! You can earn a gift card by visiting 5 vendors!

Mammograms & On-Site Health Screenings will also be available. More information about location and times will be shared at a later date!

Check the One Rockwood Retiree Wellness page for dates for biometric screenings and the registration link.

Required Notifications

Retiree Benefit Guide

Definitions

Retiree – A retiree of the District who retires with the Missouri Public School Retirement System (PSRS) or the Public Education Employee Retirement System (PEERS).

Retirement Date – The first day of the month for which the retiree receives their first retirement benefit from PSRS or PEERS.

Eligible Spouse – Legal spouse of the retiree who does not have an offer of coverage from their employer.

Eligible Dependent – Legal dependent of the retiree who is under the age of 26.

Spouse Only Rate – The amount equal to the retiree only rate.

Child Only Rate (Underage Dependent) – The amount equal to the retiree plus child rate minus the retiree only rate.

Spouse and Child Only Rate – The amount equal to the retiree plus family rate minus the retiree only rate.

Open Enrollment – The annual time when benefit changes can be made.

Retiree Eligibility

Retirees may continue district health coverage provided that they elect to continue health coverage within one (1) year from the date they retired from the district. The election must be made by following District procedures.

If a retiree passes away, any spouse or child on the plan at the time of the retiree's passing, may continue to remain on the plan as long as:

- premiums continue to be paid
- until the child turns 26
- as long as the spouse is not offered coverage through their employer.

The foregoing is not intended to limit or change any benefits or features provided under District health coverage under the Affordable Care Act or COBRA.

If a spouse or children are covered under the district's health plan on the retiree's date of death and are eligible for special enrollment under RSMo § 169.590, such individuals may continue coverage under the district's health plan, provided that such individuals pay for the cost of coverage and enrollment is made following District procedures within 30 days of the date of death. Once enrollment deadlines have passed, enrollment is not permitted.

As a retiree, you are responsible for the full amount of premiums, which includes the portion the district paid for you, and the portion you previously paid for any family members you had on your plan. You can elect retiree only, retiree plus spouse, retiree plus child, or retiree plus family.

The above eligibility rules shall apply to dental and vision as well.

Retiree Enrollment

A retiree should apply for retiree health coverage at least 30 days prior to their active coverage ending to avoid a temporary lapse in coverage. Assuming timely enrollment, the effective date of the retiree coverage will be the first day of the month following their benefit end date as an active employee. Once benefit elections are submitted, dependents or spouses can only be added due to a Special Enrollment for certain life events or new dependents/spouses or at Annual Open Enrollment.

Retiree Health and Other Coverage Checklist

Be sure to complete the following checklist to enroll for retiree health benefits:

- Complete and submit to the Benefits Office the RSD Retiree Enrollment Form towards the back of this book or submit elections through the on-line enrollment site (Alight) if applicable, whether electing or waiving.
- Complete and submit the Automatic Debit Authorization form along with a voided check.
- Bank accounts are debited for premium payments the 7th of the month for the current month, or the next business day if the 7th lands on a holiday or weekend.
- Submit a copy of your proof of retirement through PSRS or PEERS showing your eligibility as a retiree and listing your spouse or dependents.
- If you or your spouse is eligible for Medicare, contact your local Social Security Administration office to enroll in Parts A, B, and D of Medicare. It is important to enroll in Medicare Parts A, B, and D to receive maximum health benefits. If Medicare is not elected and you or your spouse are eligible for Medicare, benefits under the district's health plan will be reduced as though Medicare is the primary payor.

Complete the employee portion of the Portability and Conversion form and return to Benefits no more than 30 days after your last day of work if you wish to convert your retiree life insurance to an individual life policy. The Benefits office will complete the rest and send it in to Hartford. The life carrier will determine the premium amounts. This will be billed through the life carrier.

Open Enrollment

Retirees will have the opportunity to make changes to their health benefits each year at open enrollment provided those changes are consistent with the eligibility rules stated herein.

You have one year from your retirement date to elect benefits. If you do not, you can never enroll in them. This includes medical, dental, vision and EAP. If you ever enroll in any of the 4 options and drop any of them, you can never add the ones you dropped back on.

Coverage is provided on a monthly basis and months of coverage and premiums are not pro-rated.

Special Enrollment Periods due to Loss of Other Health Coverage

An eligible (under age 26) dependent of a covered retiree (or covered surviving spouse) who loses coverage under another health plan will be eligible to enroll for coverage in the district's health plan if the following apply:

- The covered retiree (or covered surviving spouse) declined coverage for the dependent when first eligible because the dependent was covered by other health coverage; and
- The dependent lost other coverage as a result of any of the following qualifying events: Divorce or legal separation causes the dependent to lose coverage; or the dependent is no longer eligible for coverage because the dependent is no longer considered a dependent under the other plan because of age, work or school status

(loss of coverage due to non-payment of premiums does not qualify); death of the retiree covered by the other plan; reduction in the number of hours of employment; the plan decides to no longer offer any benefits to a class of similarly situated individuals; the employer contributions to the other plan cease regardless of whether the individual is still eligible for coverage under the other plan; the individual was in an HMO or other arrangement and no longer resides, lives or works in the service area; or the dependent's COBRA continuation coverage has expired.

To enroll for coverage under these circumstances, a Retiree Enrollment Form must be submitted within 30 days of losing coverage under the other plan and appropriate premium payments must be made. This 30-day period is the special enrollment period for these events.

As part of the application process, proof of loss of coverage must be provided. If these requirements are met, coverage under the district's health plan will take effect the first day of the following month following receipt of the Retiree Enrollment Form.

Special Enrollment Period as a Result of Gaining a New Dependent or Spouse

A covered retiree (or covered surviving spouse) may enroll a new dependent if the new dependent was acquired as a result of any of the following qualifying events:

- Marriage
- Birth
- Adoption, or placement in anticipation of adoption
- Placement for foster care
- Legal guardianship
- Legal custody, or
- Qualified Medical Child Support Order (QMCSO)

To enroll the new dependent, a Retiree Enrollment Form must be submitted within 30 days of the date of the qualifying event and the appropriate premiums must be paid. This 30-day period is the special enrollment period for these life events.

District's Right to Request Documentation

Documentation of dependent relationship, such as marriage license or birth certificate, must be provided. To enroll a child due to adoption, placement in anticipation of adoption, placement for foster care, legal guardianship, or legal custody, a copy of the applicable court order must be submitted with the Retiree Enrollment Form.

Retiree Reemployment

A covered retiree who returns to work (other than full-time) while continuing to receive retirement benefits will remain covered as a retiree. The retired retiree will not be eligible for employer-paid coverage as an active retiree under the district's health plan. A retiree who returns to full-time employment is eligible for employer-paid coverage as an active retiree.

Changes in Enrollment Status

Any change in enrollment status, such as death, divorce, entitlement to Medicare, etc., must be reported within 30 days of the event. The change must be reported on the Retiree Enrollment Form. This form is in the back of this book on page 54.

The above rules shall apply to dental and vision as well. Dependents can enroll in dental and/or vision coverage up to the end of their 26th birthday.

Participants Eligible for Medicare

The district's health plan offerings provide for a Medicare Advantage plan. The eligible spouse of a retiree can elect the Medicare Advantage plan provided the non-Medicare eligible retiree remains in the district's non-Medicare medical plan. The Medicare eligible retiree can elect the Medicare Advantage plan and the eligible spouse of the covered retiree can remain on the non-Medicare medical plan. In all events, the premiums for the applicable plan must be paid.

The district's non-Medicare eligible Green and Tan plans are creditable coverage under Medicare Part D.

An individual becomes eligible for Medicare Part A on the 1st of the month in which he or she turns 65. If the birthday occurs on the 1st of the month, he or she would be eligible for Medicare on the 1st day of the previous month. To elect Medicare Part A or Part B please contact Social Security directly. Medicare will be regarded as the primary insurance over the district's health plan once a District retiree electing to be covered under the district's health plan as a retiree, retires and has reached age 65.

The following discussion assumes the facts in the preceding sentence apply. If you are eligible to be covered under Medicare but have not elected Medicare, the health plan will estimate what Medicare would have paid. This means that the district's health plan will not consider for reimbursement any costs that would have been paid under Medicare. If you purchase an individual Medicare supplement or advantage policy and also elect coverage under the district's health plan, Medicare will be primary. The district's health plan will be secondary as it does not coordinate with individual plans. You must consult the supplemental or advantage carrier to determine what coverage it will provide in these circumstances.

This summary regarding Medicare and coordination of coverage with Medicare does not address details concerning Medicare eligibility and or enrollment nor does it address all of the circumstances and situations in which Medicare may be primary or secondary. For questions about coordination of benefits, please call the customer service number on your District health plan ID card or contact the Rockwood Benefits department and ask for a copy of the health plan summary plan document. You may also contact Medicare with your questions at a local office, Medicare.gov or 1-800-633-4227.

Cancelling Coverage

A retiree desiring to terminate retiree coverage in the district's health plan must send a written request to the Benefits Office to cancel coverage under the plan. Once coverage is canceled (after the one-year special retiree enrollment period permitted under RSMo §169.590), the coverage cannot be elected at any point in the future. Once the retiree cancels his/her coverage, all rights to District health coverage for dependents and spouse cease.

Where coverage is canceled for a benefit eligible person, the coverage will end at the end of the month in which the written request is received. Dependent coverage ends at the same time the retiree coverage ends. If coverage ends due to loss of eligibility, coverage ends at the end of the month in which eligibility is lost. Requests for retroactive cancellation are not allowed. Termination of coverage ends all rights of the enrollee to benefits under the district's health plan as of the date coverage ends.

Retirees desiring to cancel dependent coverage other than at open enrollment must make this request within 30 days of the dependent gaining other coverage.

Coverage under the District's health plan will also end if any required contributions are not paid, or if the district's health plan is terminated.

Missed Payments

If the retiree misses a payment, the district reserves the right to cancel coverage at the end of the month for which payment was made unless payment is made during the grace period. Retirees who miss a payment will be given a late/missed payment notice describing the grace period to submit the late/missed payment.

Authority

The district has exclusive authority to determine eligibility for coverage under its benefit plans. The decision of the district on all matters related to retiree/dependent eligibility and any determinations by the district of disputed issues are final and binding on all parties.

Mental Health Parity and Addiction Equity Act Disclosure

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Company Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at **Benefits Office, Rockwood School District 636-733-2043.**

COBRA

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. After a qualifying life event, 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 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.

You will be offered the same medical, dental, vision and EAP plans you are enrolled in as an eligible Retiree, but you will pay 102% of the cost of the plans you elect to enroll in through COBRA. You will have 60 days from the date your benefits end to enroll. For more information, please call 636-733-2043.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

NEWBORNS ACT DISCLOSURE – FEDERAL

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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

MotivateMe® is a voluntary wellness program available to all benefit eligible retirees and spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve retiree 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 preventative exam with your primary care doctor.

However, retirees who choose to participate in the wellness program will receive an incentive of $100 minimum in gift cards and other miscellaneous prizes not exceeding $300 for completing the incentive activities. Although you are not required to complete the health risk assessment or preventive exam, only retirees who do so will receive the incentive rewards. Additional incentives of up to $200 (besides the $100 earned for completing the Physical and HRA) may be available for retirees who participate in certain health-related activities, for example: online coaching, cancer screenings, or achieve certain health outcomes. Spouses who choose to complete a preventative exam and online health risk assessment will receive an incentive of a $50 gift card.

All incentive rewards earned will be regarded as taxable income.

For all participants – if you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Cigna at 1-800-CIGNA24 and they will work with you and, if you wish, with your doctor.

For participants who may have an impairment – if you are unable to participate in any of the program events, activities or goals, because of a disability you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For work-site accommodations please contact Brenda Tinsley, Rockwood School District Benefit Coordinator at tinsleybrenda@rsdmo.org or 636-733-2043, for accommodations with online, phone, or other Cigna programs, please contact Cigna at 1-800-CIGNA24.

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, and may also be used to offer you services through the wellness program, such as "online coaching", "telephonic coaching", or other applicable services. You are also 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 Rockwood School District may use aggregate information it collects to design a program based on identified health risks in the workplace, MotivateMe® 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 are registered nurses, health coaches, or doctors 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 **Brenda Tinsley, 111 E North Street, Eureka, MO 63025, 636-733-2043, tinsleybrenda@rsdmo.org.**

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****.*

Contact information for questions or complaints is available at the end of the notice.

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 your 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, usually 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.

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 up to 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 complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- 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 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- 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.

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.

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.

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/hipaa/for-individuals/guidance-materials-for-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/hipaa/for-individuals/guidance-materials-for-consumers/index.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 (if applicable), and we will mail a copy to you.

Other Instructions for Notice
- Effective November 1, 2025
- Contact Information:
  Brenda Tinsley
  111 East North Street
  Eureka, MO 63025
  636-733-2043
  tinsleybrenda@rsdmo.org

Medicare Part D Creditable Coverage Notice

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Rockwood 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 Rockwood 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. **Rockwood School District has determined that the prescription drug coverage offered by the Cigna Deluxe Green Plan and the Cigna Tan Plan (High Deductible Plan) for the plan year 2025-26 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Cigna Deluxe Green Plan or the Cigna Tan Plan (High Deductible Plan) and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Cigna Deluxe Green Plan or Cigna Tan Plan creditable coverage.
- You may stay in the Cigna Deluxe Green Plan or the Cigna Tan Plan and also enroll in a Medicare prescription drug plan. The Cigna Deluxe Green Plan or the Cigna Tan Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.

- You may decline coverage in the Cigna Deluxe Green Plan or the Cigna Tan Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Cigna Deluxe Green Plan or the Cigna Tan Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Rockwood 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.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Rockwood 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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:	November 1, 2025
Name of Entity/Sender:	Rockwood School District
Contact--Position/Office:	Brenda Tinsley
Address:	111 E. North Street, Eureka, MO 63025
Phone Number:	636-733-2043

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 or Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact or Coordinator of Benefits at 636-733-2043.

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.

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 Rockwood School District	2. Employer Identification Number (EIN) 43-6004215	
3. Employer address 111 E. North Street	4. Employer phone number 636-733-2000	
5. City Eureka	6. State MO	7. ZIP code 63025
8. Who can we contact about Retiree health coverage at this job? Brenda Tinsley		
9. Phone number (if different from above) 636-733-2043	10. Email address tinsleybrenda@rsdmo.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All Retirees. Eligible Retirees are:
  - ☒ Some Retirees. Eligible Retirees are:

    A retiree of the District who retires with the Missouri Public School System (PSRS) or the Public Education Employee Retirement System (PEERS) on the same date.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse (if not offered insurance through their employer)
    Married dependent(s) to age 26
    Unmarried dependent(s) to age 26

  - ☐ 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 Retiree 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 Retiree 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.

Glossary

Annual Open Enrollment – The one time per year when Retirees can make changes to their benefits (unless there is a qualifying life event).

Coinsurance – Typically in a percentage, this is the percentage of a cost of a service that you pay. The plan pays the other percentage of the cost. You will typically pay coinsurance after you meet the deductible.

Copay – The fixed dollar amount for certain services like a primary care visit or prescription.

Deductible – A health plan deductible is what you pay before the plan starts to pay.

Dependents – Children and spouses the Retiree chooses to cover on their insurance.

Embedded Deductible – In a health plan with an embedded deductible, no single individual on a family plan will have to pay a deductible higher than the individual deductible amount. Our Green Plan has an embedded deductible. That means if there are two on the plan, each person has to reach their individual deductible before the coinsurance kicks in. If there are more than two on the plan, at least one person has to meet the individual deductible. The others, together, need to reach the remaining deductible. Our Tan Plan does not have an embedded deductible. That means one person can reach the deductible for the whole family.

HSA – Health Savings Account. Established by the IRS, this benefit allows the use of pre-tax salary to be used for qualified medical expenses. The account owner must be in a high deductible health plan (i.e. the Tan Plan).

Life Event – A change in status or life event that could qualify a Retiree to request a special enrollment. Examples include marriage, birth, divorce, gaining or losing other coverage. Please see One Rockwood or contact the Benefits Office for more information if you think you might qualify.

Out-of-Pocket Max – This is the yearly maximum you would pay in medical expenses not including premiums.

Plan Year – The period between November 1 and October 31 each year is our plan year. Plan changes and premium changes can happen at the start of each plan year.

Premiums – The amount you and the district pay to have coverage.

Self-Funded Insurance – Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying Retirees' and dependents' medical claims. In RSD we contract with Cigna, Express Scripts, and Delta Dental for the use of their networks and for them to process, pay, and adjudicate claims.

Your cost of health care is the amount of premiums you pay and the amount you pay in out-of-pocket costs like your deductible and expenses up to your out-of-pocket maximum.

RSD Benefits Office Staff

Please contact the Benefits Office if you have questions or need further information. Copies of the benefit summaries can be found at worklife.alight.com/rockwoodschools.

Coordinator of Benefits — Brenda Tinsley
636-733-2043
tinsleybrenda@rsdmo.org

Benefits Specialist — Amber Gogel
636-733-2006
gogelamber@rsdmo.org
Amber helps retirees with enrolling in benefits, making changes to benefits, and child rearing leaves.

Human Resources Assistant — Kim Vaughn
636-733-2050
vaughnkimberly@rsdmo.org
Lisa enters benefit payroll deductions, processes COBRA, and manages online trainings.

Human Resources Assistant — Laura Lovendahl
636-733-2009
lovendahllaura@rsdmo.org
Laura handles medical leaves of absence (non-child rearing leaves) and worker's compensation.

On-Site Cigna Rep/Wellness Coordinator — Lisa Livingston
636-733-2062
livingstonlisa@rsdmo.org
Amber helps with incentives and anything wellness related.

Rockwood School District is proud to offer a comprehensive benefits package to eligible Retirees. The complete benefits package is briefly summarized in this booklet. For more detailed information, please log on to worklife.alight.com/rockwoodschools and review Summary Plan Descriptions and Schedules of Benefits for each option.

If you have any questions or concerns regarding any information in this booklet, please contact the RSD Benefit Office.

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we've tried to summarize the provisions of these legal documents clearly and accurately, if any information presented here conflicts with the legal documents, the legal documents will govern.
For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents. All benefit plans are subject to change. RSD reserves the right to amend or cancel any benefits in this booklet in whole or in part at any time and for any reason. This document does not guarantee any benefits.

Retiree Enrollment Form 2025-26

Name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Phone: _____

	PER MONTH	Total Cost of Coverage	If adding Dependent(s) List their name, SSN and DOB
	Medical – Choose one option		
	Green		
	Retiree	$722.90	
	Retiree + Spouse	$1,548.78	
	Retiree + Child(ren)	$1,346.86	
	Retiree + Family	$2,172.90	
	Tan		
	Retiree	$590.58	
	Retiree + Spouse	$1,251.28	
	Retiree + Child(ren)	$1,089.76	
	Retiree + Family	$1,750.64	
	Aetna (Coventry)	I have contacted Aetna (Coventry) to enroll in the RSD Medicare Advantage Plan.	
	Waive all Medical		
	Dental – Choose one option		
	Retiree	$38.26	
	Retiree + Spouse	$75.42	
	Retiree + Child(ren)	$83.38	
	Retiree + Family	$120.62	
	Waive all Dental		
	Vision – Choose one option		
	Retiree	4.78	
	Retiree +1	8.52	
	Retiree + 2	12.76	
	Waive all Vision		
	Employee Assistance Program		
	Retiree	$1.65	
	Waive		

Signature: _____ Date: _____

Please return this form to:

111 E North Street
Eureka, MO 63025

Or email to
benefits@rsdmo.org

Failure to provide appropriate documentation can result in loss of coverage changes.
By submitting the coverage selections for my listed dependents and myself, I agree to the following:

- Payment is due the 7th of each month through electronic funds transfer from my designated account.
- Requested changes will become effective 1st of the month following receipt of request for change.
- Selections under the Plan can be changed or revoked by me only at each annual enrollment, on account of, and consistent with a Life Event (as defined by the Plan), or as otherwise permitted under federal law, including the HIPAA Special Enrollment regulations.
- The information I have furnished, to the best of my knowledge and belief, is correct and complete.
- I understand that any person who knowingly and with the intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.
- I understand all benefits are subject to conditions stated in the Plan Document.

_____

Office use only:
Date received: _____
Date documents received: _____
Date conformation sent to retiree: _____

2025-26 Rockwood School District
Retiree Group Insurance Rates
November 1, 2025 to October 31, 2026

Green Medical Plan	Monthly Contribution
Retiree	$722.90
Retiree & Spouse	$1,548.78
Retiree & Child(ren)	$1,346.86
Retiree & Family	$2,172.90
Underage Dependent	$623.96
Spouse/Dep Only	$722.90

Tan Medical Plan	Monthly Contribution
Retiree	$590.58
Retiree & Spouse	$1,251.28
Retiree & Child(ren)	$1,089.76
Retiree & Family	$1,750.64
Underage Dependent	$499.18
Spouse/Dep Only	$590.58

Dental Plan	Monthly Contribution
Retiree	$38.26
Retiree & Spouse	$75.42
Retiree & Child(ren)	$83.38
Retiree & Family	$120.62

Vision Plan	Monthly Contribution
Retiree	$4.78
Retiree +1	$8.52
Retiree + 2	$12.76

Employee Assistance Program	Monthly Contribution
Retiree	$1.65

Once a line of coverage is discontinued, the retiree cannot return to that line of coverage.

Enrollment in each line of coverage is independent from the other lines of coverage.

*EAP Coverage must be elected for the entire plan year. If EAP enrollment is not elected at the initial offer of coverage, the retiree cannot elect EAP at future Open Enrollments.

This brochure summarizes the benefit plans that are available to Rockwood School District eligible Retirees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.