2026 Benefits Guide

Your Health & Wellness

Retiree Benefits

PARKWAY SCHOOLS

Contents

Welcome to Your 2026 Benefits!

Parkway School District is pleased to provide you and your family with a wide range of competitive benefits. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully and ask questions if needed.

Highlights:

No changes in coverage or premiums for Delta Dental

NEW! NVA Vision Care Plan!

Check out changes to the medical plans on page 11

Continued access to CareATC, if you elect the UHC Medical Plan

Please visit the benefits and wellness site for great resources including mental health:

https://www.parkwayschools.net/contact/departments/benefits

Open Enrollment

The open enrollment period for 2026 health insurance is November 1, 2025 - November 30, 2025. All changes must be processed and submitted to Parkway 4:00 PM (CST) on November 30, 2025. Any changes are effective January 1, 2026.

You **must** complete open enrollment if any of the following apply:

Your current election will not roll over.

- You are currently enrolled in the Premium Plan.
  - Select the High Deductible or Base Plan to avoid termination of your medical coverage.
- Enrolling in new coverage or ending current benefits.
- Adding/removing dependents.
- Any other changes to your current elections.

You do not need to complete open enrollment for the following:

Your current election will roll over.

- If you are currently enrolled in one of the following plans, your election will roll over to next year.
  - United Healthcare (Base or High Deductible)
  - Anthem BCBS (Medicare Advantage)
  - Aetna (Medicare Advantage)
  - Delta Dental of MO
  - EyeMed Vision (Current EyeMed members will be automatically enrolled in the NVA plan)

Dependents

- Any dependents currently covered on any plan will continue to be covered next year.

Your enrollment must be completed online through your benefits portal, Alight Worklife. If your email address is on file, you will receive an email on November 1, 2025 with more instructions and your login details. If you do not have an email address, paper forms are available upon request only. Please contact the Benefits Department to request a form be mailed to you. All communications and reminders for 2026 Open Enrollment will be sent by email, if we have an email address on file. To confirm we have the correct email address on file or request a paper enrollment form:

- **Email us at benefits@parkwayschools.net, or**
- **Call (314) 415-8059/8049**

Changing Coverage During the Year

Changing Benefits After Open Enrollment

During the year, you cannot make changes to your medical, dental, or vision plans, unless you experience a Qualified Life Event, such as Marriage, Divorce, Spouse lost coverage, etc. If you experience a Qualified Life Event (examples below), you must contact the Parkway Benefits Department. A written notice should be provided to the Parkway Benefits Department within 30 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

When HR notifies the Benefits Department about an employee's retirement, the retiree will receive an email with a retirement packet. This packet has important details about benefit options and coverage. Retirees can also visit the Benefits website anytime for the latest information. If retirees decide not to keep medical, dental, or vision coverage right after retirement, they have one year from when their district-paid benefits end to re-enroll in Parkway's group coverage. During this one-year period, they can also add a spouse or dependent children under 26 to their coverage. This deadline is strict—no extensions are allowed. State law lets retirees add a spouse or dependent at any time during the first year after retirement, not just during open enrollment. For example, if someone retires on June 30, 2025, they have until June 30, 2026, to add family members. For questions or help with insurance, retirees can contact the Benefits Department at (314) 415-8059 or email benefits@parkwayschools.net.

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Guidelines for Retiree Benefits

The Retiree Guidelines below are subject to change. For current guidelines, please visit our website (https://www.parkwayschools.net/contact/departments/benefits) and review the Retiree Benefits Handbook.

Retiree Insurance Coverage

Retirees can continue their participation in Parkway's group medical, dental and vision plans. We do not offer group life insurance or other voluntary insurances to retirees. However, employees who retire or leave the district shall have the opportunity to convert their life insurance to individual policies, subject to the limitations established by the insuring company.

Status as a retiree is determined by qualifying for benefits under the state retirement system. Retirees should visit the Parkway Benefits webpage for the most up to date information on their benefits options and coverage.

New Retiree Enrollment

Retirees who wish to enroll in Parkway's retiree benefits must follow the district's enrollment process to ensure their coverage begins without a lapse. This process applies to both newly retired employees and retirees returning to Parkway's coverage within one (1) year of their employee benefits end date.

The Benefits Department will send information via email on how to continue group health coverage after an employee notifies HR of their planned retirement date. Coverage begins on the first day of the month following your employee benefits end date, provided you have submitted all required forms and payment has been received. Retirees may add a spouse or dependent child(ren) (under age 26) to their coverage during the one (1) year period.

Retirees who choose not to continue their medical, dental and/or vision coverage at the time of retirement will be granted one (1) year from the date their district-paid benefits end to return to Parkway's group coverage in accordance with state regulation.

After the one (1) year period, retirees who cancel any individual coverage type (medical, dental, or vision), will lose eligibility to re-enroll in that specific coverage. This restriction applies to future open enrollment periods and qualifying life events (QLEs). It is essential for Retirees to carefully consider their decision to decline or leave any coverage, as this choice cannot be reversed after the one-year window has passed.

Canceling Coverage (not a qualifying life event)

Retirees may cancel their group health insurance coverage at any time. However, coverage will be in effect until the end of the month in which we receive a cancellation request.

To cancel coverage, retirees must process the change in the district's benefits software. Alternatively, a paper form may be requested by contacting the Benefits Department. Any changes must be processed and received by the district no later than 5 business days prior to the first day of the month that you wish to drop coverage. Example: To drop coverage on 5/1/2025, you would have to process the change in the benefits software no later than 5 business days prior to 5/1/2025.

Guidelines for Retiree Benefits

Payment of Premiums

Retirees who choose to continue their group health coverage are responsible for paying the full cost of their premiums. Payment is collected via ACH direct debit from one (1) bank account which can be set up by the retiree. The account on file can be changed at any time by submitting an ACH Authorization Form, provided we are notified 5 business days prior to the next scheduled payment. Retirees can choose for their monthly payment to occur on either the 1st or the 15th of each month. Payment is for the current month of coverage. Alternatively, payment can be made on an annual basis via direct debit or check to cover the full plan year.

When a scheduled ACH payment is returned by a retiree's bank, the Parkway will attempt to notify the retiree by email, or mail if no email address is on file. Upon receipt of a notice, we request that payment arrangements be made for the returned payment. A $10 return fee will be charged per failed transaction.

Retirees will be notified of past-due balances before termination. However, if payment is not received within 60 days from the due date, coverage will be permanently terminated with no option to reinstate. Additionally, any account with several consecutive late payments will be considered for termination.

HSA funds will not generally be accepted as payment for retiree insurance premiums. In alignment with IRS Publication 969:Health Savings Accounts and Other Tax-Favored Health Plans, you can't treat insurance premiums as qualified medical expenses unless the premiums are for any of the following:

1. Long-term care insurance. CAUTION

2. Health care continuation coverage (such as coverage under COBRA).

3. Health care coverage while receiving unemployment compensation under federal or state law.

4. Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

For further guidance, please review IRS Publication 969 or consult with a licensed tax preparer. Parkway can not provide tax advice and is not liable for any consequences related to the use of or contributions to HSA funds after retirement.

Medicare Eligibility

Retirees who become eligible for Medicare are required to notify the Benefits Department if they wish to cancel their Parkway group health coverage. Enrollment in Medicare does not automatically cancel your Parkway coverage. You must contact us directly to initiate any changes.

Parkway offers two (2) fully-insured Medicare Advantage plans for Medicare-eligible retirees and their eligible spouses. These plans are administered by third-party insurance carriers and are not self-funded or managed by Parkway. Enrollment is optional and provided as a courtesy for retirees who prefer this type of Medicare coverage.

Retirees will be notified of Medicare Advantage options during annual Open Enrollment, and Plan materials will be provided upon request. Parkway recommends that retirees consult with an insurance broker or Medicare advisor to understand how enrollment in one of these plans may affect other Medicare options (e.g., Medigap or Part D coverage). To sign up or to request cancellation of group coverage due to Medicare enrollment, please contact the Benefits Department.

Guidelines for Retiree Benefits

Annual Open Enrollment

Parkway hosts an annual Open Enrollment period each year, during which retirees may review their current coverage, make allowable changes, and receive updated Plan information for the upcoming year. Open Enrollment materials are posted on the Benefits webpage and distributed via email no later than the 1st day of the enrollment period.

COBRA after Retirement

The Benefits Department will offer COBRA Continuation Coverage to the qualified beneficiaries of retirees when necessary according to COBRA regulation. Qualified beneficiaries who elect COBRA coverage are responsible for the full cost of their premiums, as defined under federal COBRA law.

A retiree or qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce (or legal separation if that results in loss of plan coverage) or a child ceasing to be covered as a dependent under the Plan's rules. Also, a qualified beneficiary must notify the plan administrator within 60 days of those events when they occur during the initial 18 or 29-month period of coverage in order to qualify for an extension of the coverage period to 36 months. If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, the employee or qualified beneficiary must notify the plan administrator within 60 days of those events, as well.

Coverage for Members not eligible for Medicare

United Healthcare
Express Scripts
& Health Programs

Medical – United Healthcare

Parkway School District's medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care.

The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** —a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting the myuhc.com. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

	BASE PLAN	HIGH DEDUCTIBLE PLAN
	Choice Plus	Choice Plus
	In-Network	In-Network
Calendar Year Deductible		
Individual	$1,100	$4,000
Family	$3,300	$8,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)		
Individual	$5,000	$4,000
Family	$10,000	$8,000
	You pay	You pay
Coinsurance	10%	0%
Preventive Care	No Charge	No Charge
Primary Care Physician	$25	Deductible
Specialist	$50	Deductible
Urgent Care	$75	Deductible
Emergency Room	$200	Deductible
Lab & X-ray	Deductible then 10%	Deductible
Hospitalization	Deductible then 10%	Deductible
Diagnostic Imaging (MRI/CT)	Deductible then 10%	Deductible

UHC ONLY Medical Premium Rates

	Retiree Only	Retiree & Spouse	Retiree & Spouse + 1 Child	Retiree & Spouse & 2+ Children	Retiree & 1 Child	Retiree & 2+ Children
Base	$1,049.98	$1,728.06	$2,060.30	$2,419.94	$1,382.08	$1,728.06
High Deductible (HSA)	$786.56	$1,304.78	$1,626.36	$1,962.64	$1,048.00	$1,328.84

Pharmacy

Just like your medical plan covers visits to your doctor, your Express Scripts prescription plan covers the medication your doctor prescribes.

A 3-tier copay structure applies for both plans, but when enrolled in the high deductible health plan you pay the full cost of the medication until you meet the deductible.

The SaveON SP program is available to you, please see page 12 for more information.

	BASE PLAN	HIGH DEDUCTIBLE PLAN
Pharmacy		
Rx Deductible	N/A	Medical Deductible Applies
Rx Out-of-Pocket Max Individual Family	 $5,000 $10,000	 N/A N/A
Retail Rx (up to 30-day supply)		
Tier 1	$12	Full cost until the $4,000 Deductible is met; then 100% covered in Network
Tier 2	$40	
Tier 3	$60	
Mail Order Rx (90-day supply)	$24 / $80 / $120	

Note: If you request a brand-name medication when a generic equivalent is available, you'll pay your cost share, plus the difference in cost between the brand and the generic.

PAY $0 FOR SELECT SPECIALTY MEDICATIONS

Participate in the SaveOnSP program

Specialty medications can cost a lot of money. That's why your plan offers a program called SaveOnSP, to lower your out-of-pocket costs to $0.

Participate in SaveOnSP and save.

Over 300 specialty medications are eligible for the SaveOnSP program.[1] If you're filling an eligible medication, a representative from SaveOnSP will contact you to discuss the program.

You'll pay $0 for your medication when you participate in SaveOnSP. If you choose not to participate, you'll pay a higher cost share when you fill your medication.

Conditions covered by SaveOnSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis
- Cancer

Here's an example of how it works.[2]

John's taking a specialty medication that's eligible for the SaveOnSP program. His copay is currently $70. His new cost share will be $1,150.

- **When he participates in SaveOnSP, he won't pay anything ($0) out-of-pocket.** He will work with SaveOnSP to enroll with the applicable manufacturer copay assistance program.
- **If he decides not to participate in SaveOnSP, he'll pay his full cost share of $1,150 out-of-pocket.**

In both of these examples, John's cost share wouldn't count toward his deductible or out-of-pocket maximum.

1. The drug classes and medications in this program are subject to change. Check your plan materials to see which medications are eligible for the SaveOnSP program.
2. For illustrative purposes only. Plans may vary.

EXPRESS SCRIPTS® SaveOnSP

United Healthcare Programs

Register for your personalized website on myuhc.com and download the United Healthcare app.

Get the most out of your benefits! These digital tools are designed to help you understand your benefits and make informed decisions about your care.

Find care and compare costs for providers and services in your network. Check your plan balances, view your claims and access your health plan ID card. Access wellness programs and view clinical recommendations. View your health care financial account(s) such as HSA or FSA.

Real Appeal

Real Appeal is a weight loss and health lifestyle program, available to eligible Parkway School District employees and their dependents as part of our United Healthcare Benefit plan. It is a simple, step-by-step program designed to introduce small changes over time that lead to healthier habits and long-lasting weight loss results. The program is offered at no additional cost to employees, spouses/domestic partners and dependents 18 and older who are members of our United Healthcare plan with a BMI (body mass index) of 23 or higher. Your BMI will be calculated during a personalization session to confirm that you qualify for the program. Participation in Real Appeal is confidential, and information will not be shared with Parkway School District. This is a great opportunity to take charge of your personal health or team up with a loved one to lose weight and learn some healthy new habits.

This program is not available if you are Medicare Eligible.

24/7 Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. 24/7 Virtual Visits provide fast, convenient, on-demand access to care without having to leave home or the workplace. Members have the ability to see and speak with a doctor anywhere, anytime on a mobile device or computer. Members access an integrated experience through myuhc.com and the United Healthcare app..

Advocate4Me

Advocate4Me is a consumer engagement program that provides United Healthcare members with a single point of contact to address your various health needs. By calling a single toll-free number, listed on the back of your ID card, or using your preferred communication channel, members are connected with an advocate who provides them with end-to-end support, “owning their request until it’s resolved.” This service is offered at no charge to United Healthcare members.

Wellness Offerings – UHC members only

Wellness Offerings

The goal of employee/retiree wellness at Parkway is simple. We wish to create and maintain a culture of health. We wish to provide a positive, inclusive, holistic wellness programs that employees and retirees can enter and exit based on their needs and desire. Wellness programs seek to create an environment that increases health awareness, promotes positive lifestyles, decreases the risk of disease, and enhances the quality of life for employees/retirees.

Our wellness offerings include help managing chronic conditions like diabetes and high blood pressure, to onsite exercise, to learning about nutrition, to mental wellness support through our employee assistance program.

Our wellness offerings for 2026 Include (but not limited to):

- Care ATC Employee Clinics providing accessible and great primary care, Immunizations, Personal health assessments
- Partnership with local gyms, Community Ed and Fleet Feet Training to provide low-cost options for physical activity
- Real Appeal - a weight management program free to members
- Maven Maternity
- KAIA and 2nd MD
- Virtual Therapy
- Able To
- Advocate4Me
- **One Pass Select** – a holistic offering that includes physical & digital fitness options

THESE OFFERINGS ARE ONLY OPEN TO MEMBERS WHO ARE ON ANY OF THE UHC MEDICAL PLANS. ACCESS VIA myuhc.com.

In addition to the listed wellbeing opportunities, the employer sponsors various wellbeing offerings and challenges each year, related to mental wellbeing, movement, eating well and preventive care. Contact Leah Gonzalez, Wellness Coordinator at lgonzalez1@parkwayschools.net or (314) 415-8034.

Flexible, accessible health options for employees

Over 80% of U.S. consumers consider wellness a top or important priority in their daily lives.[1] One Pass Select® is designed to encourage employee wellness through flexible gym and nutrition benefits. The program includes a low-cost national gym network, digital workouts, grocery delivery service and additional options. Best of all, your employees have the freedom to choose the option that fits their needs and lifestyle.

average retail gym membership savings with One Pass Select[3]

Benefits of One Pass Select

Potential increased productivity

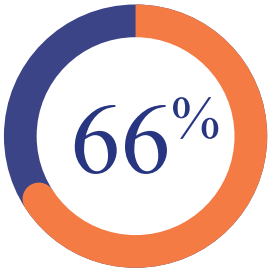
Studies show that healthier employees are typically more productive[2]

Low cost to you*, lower cost to your employees

Allows you to offer various fitness pricing options and competitive, flexible health options so employees can choose what's best for them

Convenient digital access

Convenience to browse participating gyms nationwide, a personalized dashboard and more



of employees who signed up for One Pass Select were actively engaged in the program[4]

*Self-funded groups have the option to subsidize employee costs.

continued

More advantages for employees

One Pass Select offers employees various membership tiers to choose from based on their unique fitness goals — along with additional benefits, including:

- No long-term contracts or annual gym registration fees
- Flexible fitness options with the ability to change tiers monthly
- Multi-location access with no waiting period
- The ability to add up to 4 family members (age 18+) at a 10% monthly discount
- A convenient grocery delivery subscription and additional member perks

Membership options for employees

Category	Digital	Classic	Standard	Premium	Elite
Monthly fee	$10	$34	$69	$109	$249
One-time enrollment fee	$10	$29	$29	$29	$29
Gym network size		12,000+	14,000+	16,000+	20,000+
Premium network			✓	✓	✓
Multi-location access		✓	✓	✓	✓
Digital classes	23,000+	23,000+	23,000+	23,000+	23,000+
On demand	✓	✓	✓	✓	✓
Livestreaming	✓	✓	✓	✓	✓
Workout builder	✓	✓	✓	✓	✓
Grocery delivery/other member perks*		✓	✓	✓	✓
Family memberships**	✓	✓	✓	✓	✓
Upgrade/downgrade	✓	✓	✓	✓	✓
Cancel within 30 days	✓	✓	✓	✓	✓

*The grocery delivery service component of the program is not available in TX and is pending regulatory approval in CA, NY and VA for select fully insured groups and lines of business — discuss with your UnitedHealthcare representative for details.
**10% discount.

Learn more

Contact your UnitedHealthcare representative

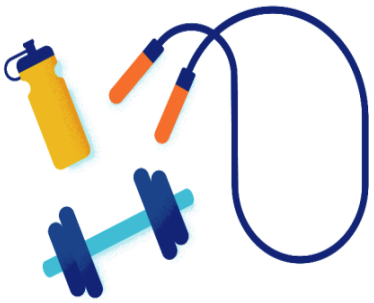
UnitedHealthcare®

surest

[1] McKinsey & Company. Future of Wellness Survey. August 2023. mckinsey.com/industries/consumer-packaged-goods/our-insights/the-trends-defining-the-1-point-8-trillion-dollar-global-wellness-market-in-2024. Accessed Dec. 5, 2024.
[2] World Economic Forum. A healthy workforce is good for business. Here's why. July 19, 2023. weforum.org/stories/2023/07/business-benefits-of-boosting-employee-health-and-well-being/. Accessed Jan. 8, 2025.
[3] One Pass Select Internal Analytics/Book of Business, 2024.
[4] One Pass Select Utilization Report, 2024. Defined as eligible members that are enrolled in the program and have utilized the benefit.

One Pass Select

Overview



Find a gym near you

Membership category	Monthly member fee	Participating fitness brands
Digital 23,000+ on-demand and livestreaming digital classes	$10	Daily Burn, Fitbit Premium, YogaWorks, Volt, Fan Huddle
Classic 11,000+ locations + digital	$34	LA Fitness, Planet Fitness, Anytime Fitness, Snap Fitness
Standard 14,000+ locations + digital	$69	CycleBar, Pure Barre, Row House, YogaSix, barre3
Premium 16,000+ locations + digital	$109	Rumble, Crunch Fitness, Pure Barre
Elite 20,000+ locations + digital	$249	Orangetheory, F45, StretchLab, 9Round, LifeTime Fitness. Club Pilates

One-time enrollment fee = $10 for Digital and $29 for all other membership tiers
Other participating locations available in our network. Updated to reflect 8/1/25 changes

Participating fitness brands

Digital (23k+)

- Daily Burn
- Fan Huddle
- fitbit premium
- Fitness On Demand
- iFIT
- Volt
- yogaworks

Classic (11K+)

- Anytime Fitness
- Crunch
- EōS Fitness
- LA Fitness
- planet fitness
- snap fitness 24/7

Standard (14K+)

- barre3
- CycleBar
- Row House
- YogaSix
- campGladiator

Premium (16K+)

- Crunch
- Rumble
- pure barre

Elite (20K+)

- 9Round
- F45
- LifeTime
- orangetheory
- StretchLab
- Club Pilates

Other participating locations available in our network. All trademarks are the property of their respective owners.
Updated to reflect 8/1/25 changes

Flexible programs to improve your health on your terms

Personalized support at no cost to you.

Diabetes Management

A personalized way to help manage diabetes. Get tools and support to track blood sugar levels and develop healthier lifestyle habits.

Program includes:

- A connected blood glucose meter
- Unlimited strips and lancets
- Tips, action plans and one-on-one coaching
- Real-time support for out-of-range readings

Hypertension Management

Take control of your heart health with guidance and a personalized plan. With a smart blood pressure monitor, you can track, get support, set up reminders and message a coach, all in one place.

Program includes:

- A connected blood pressure monitor
- Step-by-step action plans based on your goals
- Tips on nutrition and activity
- One-on-one support from expert coaches

Diabetes Prevention program

Take your first step toward a healthier tomorrow, and reduce your risk of type 2 diabetes. With the Diabetes Prevention program, you'll get access to a team of expert coaches, a library of online lessons and a smart scale— at no cost to you.

Program includes:

- Expert coaches to help with diet, nutrition, activity and more
- A smart scale that syncs to the app and web portal
- An all-in-one app to track weight, activity and food

Depending on your eligibility, you may see communications for one or more of these programs. Upon enrollment, you'll receve support for the programs that fit your unique needs.

Learn more and join

Visit TeladocHealth.com/Smile/PARKWAY or call 800-835-2362 and use registration code: PARKWAY.

Las comunicaciones del programa Teladoc Health están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al 800-835-2362 o visite TeladocHealth.Com/Hola/PARKWAY.

Program includes trends and support on your secure Teladoc Health account and mobile app but does not include a phone or tablet. You must have an iPhone or Android smartphone and install the Teladoc Health app to participate in the Teladoc Health program.

This program is offered at no cost to you by your health plan or employer.

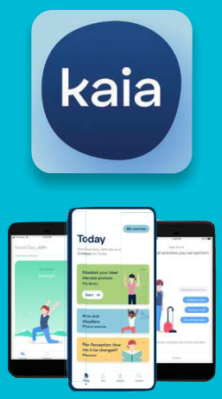
Don’t wish pain away … do this instead

Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier

Whether it’s a stiff neck, aching shoulders or more severe back issues, it can be hard to enjoy life when pain shows up. That’s where Kaia steps in. It’s a new app here to show how pain relief is possible — **at no extra cost** as part of your health plan.

Connecting with Kaia connects you with so much

- **On-demand pain relief care** in the convenience of an app
- **1-on-1 health coaching** with certified professionals
- **Workouts tailored to you** with some as short as 15 minutes
- **No extra cost—**this is included as part of your health plan
- **Bite-sized lessons** to help you recognize where pain is coming from
- **Strengthening exercises** plus relaxation techniques for pain management



Download Kaia today

You’ll get a personalized pain relief program created on the spot after you sign up. Get started with a personalized pain relief program and learn helpful exercises with no scheduling, waiting rooms or travel required.

Download on the App Store | GET IT ON Google Play

For real-time feedback while you exercise

Kaia tracks your movements using AI technology to ensure you’re doing each exercise correctly, providing real-time audio and video feedback for help along the way. So you get a program tailored to your fitness, pain and mobility levels to help manage pain.

Visit startkaia.com/uhc

United Healthcare | kaia health

*Provided at no extra cost as part of your health plan.

Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.

Reaching out may be hard—especially if you might not want anyone to know you're hurting.

From the privacy of home and the convenience of your mobile device or computer, you can receive caring support from a licensed therapist.

Virtual therapy offers confidential counseling and includes:

Private video sessions
Get 1-on-1 support—in your home and at a time that's convenient for you.

Help with coping—for children, teens and adults
Your licensed therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits
You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Anxiety
- Mental health disorders
- Addiction
- Depression

A quicker way for the whole family to get care

A virtual visit for mental health care may be a great way for children and teens to get an appointment.

To find a provider and schedule a visit

Sign in or register on myuhc.com®. Then, go to **Find Care & Costs > Virtual Care > Behavioral Health Care > Get Started** and call the provider to set up an appointment. Or call the telephone number on your health plan ID card.

*Data rates may apply.

Costs and coverage may vary. Check your plan for details.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

United Healthcare

2nd.MD
Specializing in Medical Certainty

WE SPECIALIZE IN **MEDICAL CERTAINTY**

Through your company, you have an exclusive membership to 2nd.MD, a virtual expert medical consultation and navigation service. We connect you with a board-certified, elite specialist for a virtual expert medical consultation via phone or video from the comfort of home.

2nd.MD specializes in medical certainty by providing access to elite specialists for questions about:

- Diseases, cancer, or chronic conditions
- Surgeries or procedures
- Medications and treatment plans

WHO IS ELIGIBLE?

2nd.MD is confidential, fast and no additional cost to you and covered dependents on the UnitedHealthcare medical plan.

GET STARTED TODAY

Call at 1.866.269.3534
Visit www.2nd.MD/activate
or download our 2nd.MD app

Download on the App Store | GET IT ON Google Play

CALL 911 IMMEDIATELY IF YOU ARE HAVING A MEDICAL EMERGENCY. 2nd.MD is not an emergency service. 2nd.MD is an independent resource to support you in receiving information from Expert Medical Specialists. 2nd.MD does not practice medicine or provide patient care and is independent from the Specialists providing the expert medical consultations.

HOW IT WORKS:
3 Simple Steps

1. **ACTIVATE YOUR ACCOUNT AND REQUEST A CONSULT**
   Visit www.2nd.MD/activate, download our app or call us at 1.866.269.3534

2. **SPEAK WITH A NURSE**
   Explain your medical issues and an experienced nurse will handle the rest, including collecting medical records and connecting you with a leading specialist who is an expert in your condition.

3. **CONSULT WITH A LEADING SPECIALIST** Get information about your diagnosis, treatment plan and next steps in care from a nationally recognized specialist. Consult via video or phone at a time that works best for you, including evenings and weekends!

AFTER YOUR CONSULTATION

You'll receive a written summary of your consultation so you're prepared for a conversation with your treating doctor or we can refer you to another in-network doctor in your area.

See how one member avoided an unnecessary surgery and learned how to manage her rare condition.

Real Appeal

Real tools for real change

Reach your wellness goals with Real Appeal, a healthy lifestyle and weight management program designed to help you take control of your health, all at **no additional cost** to you. Pair weekly coaching, science-backed strategies, and online tools and trackers with the **free* Real Appeal Success Kit** to support your ongoing journey toward healthier living!

What's in the kit?

Get supportive tools delivered right to your door to help you make healthier choices.

Body Weight Scale:

Track your weekly progress with this accurate and easy -to-use digital scale.

Balanced Portion Plate:

Eat balanced meals and recognize the suggested serving sizes of the foods you eat with this dishwasher-safe plate.

Food Scale:

Take all the guesswork out of food measurements with this convenient kitchen tool.

Fitness on Demand:

Access hundreds of online workouts through Fitness on Demand™ from the comfort of your home.

Ready to join?

Get started now at enroll.realappeal.com or scan the QR code.

SCAN ME

*Success Kit is provided after a member attends their first session.

Real Appeal is offered at no additional cost to members as part of their medical benefits plan, subject to eligibility requirements.

Real Appeal

Get support to build healthier habits

Now's a great time to start taking small steps for lasting change, with Real Appeal®. This online weight management program is designed to help you create a healthier lifestyle that you can maintain with confidence.

More support for more confidence

Real Appeal supports you every step of the way. It's available to you at no additional cost as part of your benefits.

Supportive coaching and sessions
Get personalized guidance from a coach, who leads collaborative weekly group sessions.

Making behavior change possible
Together, we'll address topics like emotional eating, mindset and motivation, and more.

Resources to stay motivated
Your Success Kit gives you access to online fitness classes, scales, a portion plate, and more.

Here's what you need to register:

Your calendar
Choose a weekly online session day and time that works for you.

Your shipping address
You'll receive your Success Kit after attending your first online session.

Your health insurance
Have your health insurance ID card handy when enrolling.

Get started now at enroll.realappeal.com or scan the QR code.

SCAN ME

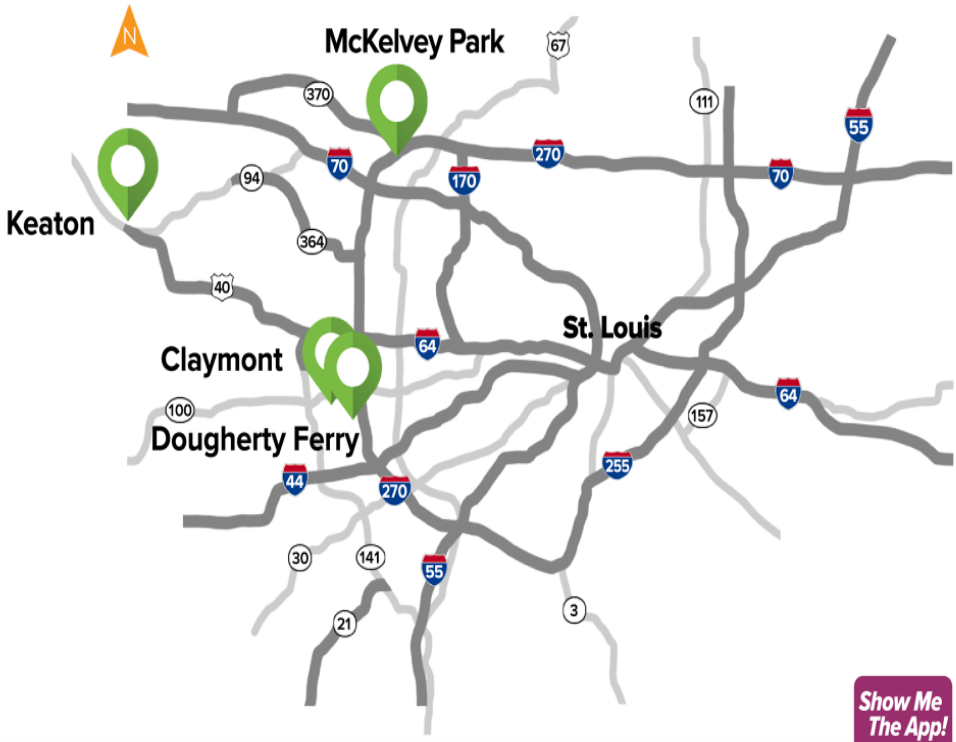
CareATC Health & Wellness Center

- **No copay or deduction required to use the health center** – Only a $40 office visit fee for HDHP Plan members who use the clinic for non-preventative services
- **Primary Care, Preventive Medicine**, Illness or Injury, Chronic Disease Management
- **Quick and easy appointments** – via the CareATC app, online or by phone
- **Less wait time, more face time** with your medical provider
- **No Cost Labs and Generic Meds** at your appointment

Area Health Center Locations

Pay nothing, get a lot.

- No co-pay
  (Office visit fee may apply for HSA participants.)
- Quick and easy appointments
- Preventive care, as well as illness, injury, and chronic disease management
- Free lab work and generic medications provided during your visit
- Less wait time, more face time with your medical provider
- No insurance billing



Show Me The App!

Claymont Health Center
15421 Clayton Rd, Ballwin
M/W/F 7am - 4pm
Tu/Th 8am - 5pm

Dougherty Ferry Health Center
2315 Dougherty Ferry Rd
Ste 110, St. Louis
M - F 8am - 12pm / 1 - 5pm

Keaton Health Center
6698 Keaton Corp Pkwy
Ste 101, O'Fallon
M/W/Th/F 7am - 4pm
Tu 9am - 6pm

McKelvey Park Health Center
3165 McKelvey Rd
Ste 205, Bridgeton
M - F 7:30am - 4:30pm

CareATC
THE POWER TO BE WELL.

Parkway Care ATC Clinic Incentive 2026

Care ATC Clinic Well Incentive= A one time $50 check for visiting the CareATC Clinics in 2026.

Participation in the Parkway clinic incentive program is strictly voluntary. In order to receive the incentive, retirees can voluntarily participate in the program by completing the steps below. The $50 incentive for visiting Care ATC is paid via mailed check.

Incentives will be paid on a rolling basis, monthly. The incentive payout will be processed about one month after the retiree completes the **form**.

In order to be eligible for the incentive you must be enrolled in one of Parkway's UHC medical plans through December 31, 2026. You must have a visit or a Personal Health Assessment (PHA) with the Parkway Employee Clinic (Care ATC) in 2026.

> **Step One:** See the clinic for preventive/wellness care, a Personal Health Assessment or even get-well care. There are two easy ways to schedule: www.careatc.com/patients, through the app or call 800.993.8244. For more details on scheduling, please see: Scheduling
>
> **Step Two:** Please let us know the date that you were seen at the clinic **here**. The deadline to complete the steps for 2026 is December 31, 2026.

Frequently Asked Questions:

1.How do I make a Care ATC Clinic appointment? There are two easy ways to schedule: www.careatc.com/patients or call 800.993.8244. For more details on scheduling, please see Scheduling

2.Is this confidential? It's the law! Your individual results are never shared with another - including your employer. Your results remain confidential and secure with Care ATC.

3.I already was a patient at the clinic - will that count? Any clinic visit in 2026 will count.

4.I had a preventive visit with my primary care provider in 2026 - will that count? We ask that you receive care with Care ATC. Keep in mind that wellbeing visits, including the PHA, are without cost to you and the information can be shared back to your own Primary Care Provider.

5.What does the Personal Health Assessment (PHA) include? Personal Health Assessments provide a snapshot of your health through laboratory screenings, medical history, and physical factors. The PHA is not a drug test. The test will include height, weight, blood pressure and 30+ lab values including cholesterol and blood glucose. More information is available on the PHA details page.

6.Do I have to change to the clinic? I like my provider. You do not have to change your primary care provider. You may have the Personal Health Assessment at the Care ATC Clinic and share those results with your primary care provider.

NOTICE REGARDING WELLNESS PROGRAM

PARKWAY

Medicare Advantage Plans

2026 Medicare Advantage Plans Overview

Private Plans

- Parkway offers two Medicare Advantage Part D plans (MAPD) through Anthem BCBS and Aetna. These cover Part C and Part D. These are not Supplemental plans.

Medicare Advantage Plan Rates

Aetna Medicare Advantage Plan Premium Rates	
Retiree	$432.43
Retiree & Spouse	$864.86

Anthem BCBS Medicare Advantage Plan Premium Rates	
Retiree	$462.23
Retiree & Spouse	$924.46

While Parkway contracts with these plans, they may not be the best fit for everyone. We strongly encourage you to explore all of your options on www.medicare.gov and to take advantage of free, unbiased counseling available through the Missouri State Health Insurance Assistance Program (SHIP) at www.missouriship.org to ensure you select the coverage that is best for your needs.

If both a retiree and their spouse wish to enroll in one of Parkway's Medicare Advantage plans, they must select the same plan. The spouse may not enroll in a different Parkway Medicare Advantage plan than the retiree. However, the spouse may choose to enroll in a Medicare plan outside of the Parkway offerings if they prefer.

Aetna Medicare Plan

Parkway School District
Aetna Medicare[SM] Plan (PPO)
Medicare (S02) ESA PPO Plan
Custom Rx $10/$30/$50/25%

Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$4,200
It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement , Dental Coverage and Medicare prescription drug coverage that may be available on your plan.	

aetna™

Parkway School District
Aetna Medicare[SM] Plan (PPO)
Medicare (S02) ESA PPO Plan
Custom Rx $10/$30/$50/25%

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	$300 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	$250
Ambulatory Surgery Center	$250
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers.**
Primary Care Physician Visits	$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$25
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services	$0

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings
- HBV infection screening

- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$50
Urgently Needed Care; Worldwide	$50

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	20%
Diagnostic Radiology Other than CT scans	20%
Lab Services	$0
Diagnostic testing & procedures	20%
Outpatient X-rays	$15
HEARING SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$25
Medicare Covered Hearing Examination	$25
Hearing Aid Reimbursement	$500 once every 12 months
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Aetna Enhanced Preventive Dental Value ESA	
Coverage for preventive dental services including cleanings, exams and x-rays	
Annual Benefit Maximum - $750	$0 dental deductible 0% coinsurance for each covered dental service
Medicare Covered Dental*	$25
Non-routine care covered by Medicare.	
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$25
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$25
Vision Eyewear Reimbursement Applies to in or out of network	$100 once every 24 months

MENTAL HEALTH SERVICES*	This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care	$300 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$25
Individual visit	
Partial Hospitalization	$25
Intensive Outpatient Services	$25
Inpatient Substance Abuse	$300 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	$25
Individual visit	

SKILLED NURSING SERVICES*	This is what you pay for network & out-of-network providers.
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $40 per day, days 21-50; $0 per day, days 51-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	This is what you pay for network & out-of-network providers.
Outpatient Rehabilitation Services	20%
(Speech, physical, and occupational therapy)	

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers.
Ambulance Services	$100

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	Not Covered
MEDICARE PART B PRESCRIPTION DRUGS*	**This is what you pay for network & out-of-network providers.**
Medicare Part B Prescription Drugs	20%
Medicare Part B Prescription Drugs - Insulin	20% up to $35
MEDICARE PART D PRESCRIPTION DRUGS	**This is what you pay for network & out-of-network providers.**

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	20%
Allergy Testing	$25
Blood	$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	20%
Intensive Cardiac Rehabilitation Services	20%
Chiropractic Services*	$20
Medicare covered benefits only.	
Diabetic Supplies*	$0
Includes supplies to monitor your blood glucose from LifeScan.	
Durable Medical Equipment/ Prosthetic Devices*	20%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$25
Outpatient Dialysis Treatments*	20%
Podiatry Services	$25
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	20%
Supervised Exercise Therapy (SET) for PAD Services	20%
Radiation Therapy*	20%
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Fitness Benefit	SilverSneakers®
Resources For Living®	Covered
For help locating resources for every day needs.	

Smoking and Tobacco Use Cessation Supplies	$0
Frequency	unlimited visits every year
Teladoc™	$0
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$10
Telehealth Specialist	$25
Telehealth Occupational Therapy Services	20%
Telehealth PT and SP Services	20%
Telehealth Other Health care Providers	$25
Telehealth Individual Mental Health	$20
Telehealth Group Mental Health	$20
Telehealth Individual Psychiatric Services	$20
Telehealth Group Psychiatric Services	$20
Telehealth Individual Substance Abuse Services	$25
Telehealth Group Substance Abuse Services	$20
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services	$20
Telehealth Urgent care	$50
Wigs*	$0
Maximum	$400
Frequency	every year

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Routine Podiatry	$25
Frequency	twenty four visits every year
Routine Physical Exams	$0
One exam per calendar year	

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Calendar-Year Deductible for Prescription Drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$10	$20	$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$30	$60	$60
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$50	$100	$100

Parkway School District
Aetna Medicare[SM] Plan (PPO)
Medicare (S02) ESA PPO Plan
Custom Rx $10/$30/$50/25%

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	25%	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,100 for covered Part D prescription drugs is reached.

Requirements:

Precertification Applies

Step-Therapy Applies

For more information about Aetna plans, go to **AetnaRetireePlans.com** or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Medical Disclaimers

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic

Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Plan Disclaimers

Aetna Medicare is a HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-

Anthem BCBS Medicare Plan

Parkway School District

2026 Summary of Benefits

PPO Plan 0P

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2026 – 12/31/2026

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$3,400 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Primary care office visit	$0 copay per visit	$0 copay per visit
Specialty care office visit	$0 copay per visit	$0 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$50 copay per visit $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$0 copay per visit	
X-ray visit and/or simple diagnostic test*	$0 copay per visit	$0 copay per visit
Complex diagnostic test and/or radiology visit*	$0 copay per visit	$0 copay per visit
Radiation therapy treatment*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$0 copay per visit	$0 copay per visit
Routine hearing services We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 benefit per ear with a $1,000 maximum benefit every three calendar years	Out-of-network providers must order hearing aids through TruHearing. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through TruHearing $500 benefit per ear with a $1,000 maximum benefit every three calendar years
Medicare-covered dental is non-routine care performed by your specialist*	$0 copay per visit	$0 copay per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Mental health professional individual therapy visit	$0 copay per visit	$0 copay per visit
Substance use disorder professional individual therapy visit	$0 copay per visit	$0 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-100 per benefit period 100-day limit per benefit period

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Outpatient rehabilitation services*	$0 copay per visit	$0 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $50 copay per one-way trip for ambulance services	
Medicare Part B drugs*	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
Chiropractic services Medicare-covered	$0 copay per visit	$0 copay per visit
Acupuncture for chronic low back pain Medicare-covered	$0 copay per visit	$0 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit	$0 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	10% coinsurance per purchase	10% coinsurance per purchase
Opioid treatment program services*	$0 copay per visit	$0 copay per visit
Podiatry services*	$0 copay per visit	$0 copay per visit
Routine foot care Includes the cutting or removal of corns and calluses, the trimming, cutting, clipping, or debriding of nails, and other hygienic and preventive maintenance care.	$0 copay per visit 12 visits per year combined in-network and out-of-network	$0 copay per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care	$0 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $50 copay for emergency care $50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $0 copay for urgently needed services
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $0 copay per admission 60 days per lifetime
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Hearing benefit management administered by TruHearing, an independent company.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026
Formulary E3, 15/30/60 (with Senior Rx Plus)

Parkway School District

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2026 – 12/31/2026

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

Below is your payment responsibility for covered prescriptions until you reach the **CMS defined drug out-of-pocket limit** of $2,100.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply (Specialty limited to a 30-day supply)	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics	$0	$0	$0
Tier 1: Generics	$15	$45	$25
Tier 2: Preferred Drugs	$30	$90	$75
Tier 3: Non-Preferred Drugs, including Specialty Drugs	$60	$180	$150

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies you will pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,100.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one-month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Extra Covered Drugs Benefits Chart

These prescription drugs are not covered under Part D, but they are provided under your Senior Rx Plus benefits. There may be instances where state regulations require these drugs to be included in your plan. These drugs do not count towards your **CMS defined drug out-of-pocket limit** of $2,100.

Pharmacy	Retail Pharmacy	Mail-Order Pharmacy
	per 30-day supply	per 90-day supply
Cough and Cold DESI Vitamins and Minerals	See Drug List for complete list of drugs covered	
Tier 1: Generics	$15	$25
Tier 2: Preferred Drugs	$30	$75
Tier 3: Non-Preferred Drugs	$60	$150
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.	
Tier 1: Generics	$15	$25
Tier 2: Preferred Drugs	$30	$75
Tier 3: Non-Preferred Drugs	$60	$150
Other Non-Part D Coverage	Copay or coinsurance	
Contraceptive Devices	$30 per Covered Device	$30 per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2026 resource: For more information, we encourage you to read Medicare & You 2026. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.gov. Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

PARKWAY

Dental & Vision

Dental and Vision

Dental Insurance

- We offer one dental plan through Delta Dental. The Assurant Dental plan is no longer available to new enrollees. Current Assurant participants will be grandfathered into the plan.
- If you decided to drop the Assurant Dental coverage you will not be able to re-enroll in the future years.
- If you have lost your Delta Dental ID card, please call Delta Dental at 314-656-3001 to request a new ID card. Parkway's Group Number is 15271000.
- There will be no increase to the Delta Dental Premiums and no increase to the Assurant Dental Premiums for the calendar year 2026.

Vision Insurance

- The vision carrier for 2026 is National Vision Administrators (NVA).
- If you have lost your NVA Vision ID card, please call National Vision Administrators at 800-672-7723 to request a new ID card. Parkway's Group Number is 3466.
- The rates did not increase in 2026.

Dental Care: Delta Dental of Missouri

The table below summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions. The network attached to the plan is the Delta Dental PPO Premier. To search the network, visit deltadentalmo.com.

	Delta Dental of Missouri	
	PPO	
	In-Network	Premier/Out-of-Network
Individual Deductible	$50	$50
Family Deductible	$150	$150
Per Individual Annual Maximum	$1,250 Per Person	
	You pay	
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments (< Age 19), Sealants, Space Maintainers (< Age 16)	0%	0%
Basic Services		
Fillings, Extractions, Endodontics	20%	25%
Major Services		
Crowns, Inlays/Outlays, Dentures and Bridgework, Oral Surgery, Periodontics	40%	45%
Orthodontia		
Adults	40%; $1,500 Lifetime Maximum	
Children (up to 26th birthday)		

Dental Monthly Premium – *NO rate increase in 2026*	
	RETIREES & COBRA/LOA
Retiree Only	$50.32
Retiree + Spouse	$88.08
Retiree & Spouse & 1+ Child(ren)	$146.58
Retiree 1+ child	$108.76

Dental Care:
Assurant – now known as SunLife Dental DHMO

This dental benefit is offered through SunLife. **Not open to new enrollees.** Only those already on this plan can continue on this plan. This dental plan is in-network only. Services received from out of network providers will not be covered under this Assurant copay plan.

	SunLife Dental Heritage Series
	DHMO Network Providers
	Basic Plan #903221
Individual Deductible	$0
Family Deductible	$0
Annual Maximum	NA
	You pay
Preventive Care	Scheduled Copayment
Basic Services	Scheduled Copayment
Major Services	Scheduled Copayment
Orthodontia	Discounts Available
Dental Monthly Premium – *NO rate increase 2026*	
Retiree Only	$14.55
Retiree + 1 Dependent (Dependent is defined as a spouse or child)	$23.45
Retiree + 2+ Dependents (Dependent is defined as a spouse or child)	$35.91

Vision Plan:
National Vision Administrators (NVA)

Parkway School District will offer vision coverage through National Vision Administrators beginning January 1st, 2026. Healthy eyes and clear vision are an important part of your overall health and quality of life.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

For information on finding a vision provider, visit www.e-nva.com and click on Find a Provider.

Vision Monthly Premium (RETIREES & COBRA/LOA) – *NO rate increase in 2026*	
Retiree Only	$5.38
Retiree + 1 Dependent	$9.64
Retiree + 2+ Dependents	$13.62

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Parkway School District
Effective 01/01/2026
Group Number: 3466

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	▪ Covered 100%	Reimbursed Amount ▪ Up to $40
Lenses Once Every Calendar Year	Standard Glass or Plastic	
▪ Single Vision	▪ Covered 100% after $20 copay	▪ Up to $30
▪ Bifocal		▪ Up to $50
▪ Trifocal		▪ Up to $65
▪ Lenticular		▪ Up to $65
▪ Polycarbonates (under age 19)	▪ Covered 100%	▪ Up to $25 (SV) ▪ Up to $30 (Bi/Tri)
▪ Solid Tints	▪ Covered 100%	▪ Up to $10
▪ Gradient Tints	▪ Covered 100%	▪ Up to $12
▪ UV Coatings	▪ Covered 100%	▪ Up to $12
▪ Scratch-Resistant Coatings (Standard)	▪ Covered 100%	▪ Up to $10
Frame Once Every Calendar Year	Retail Allowance ▪ Up to $130 (20% discount off balance)*	▪ Up to $65
Contact Lenses Once Every Calendar Year	In lieu of Lenses	In lieu of Lenses
Elective Contact Lenses	▪ Up to $130 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $104
Fit/Follow-Up***		
Standard Daily Wear	▪ Covered 100% after $20 copay	▪ Up to $20
Standard Extended Wear	▪ Covered 100% after $30 copay	▪ Up to $30
Specialty Wear	▪ Covered 100% after $50 copay	▪ Up to $50
Medically Necessary****	▪ Covered 100%	▪ Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses and contact lens evaluation/fitting once every Calendar Year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3466000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Costco, Wal-Mart / Sam's Club or LensCrafters locations or for certain proprietary brands.

**Does not apply to Costco, Wal-Mart/Sam's Club, Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target & Pearle and may be prohibited by some manufacturers.

***Only covered if you choose contact lenses.

****Pre-approval from NVA required.

Fixed prices/courtesy discount do not apply at Costco, Walmart/Sam's Club and LensCrafters locations.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $25 Polycarbonate (Single Vision) 19 & over
- $30 Polycarbonate (Multi-Focal) 19 & over
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- $80 AR Coating – Tier 4
- 20% discount AR Coating – Tier 5
- $55 High Index
- $39 Retinal Screening
- $50 Progressive Tier -1
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., Costco, LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Costco, Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., Costco, LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

COUNCIL 13 AFSCME UNION LABEL

Member Mobile App

On the go? Take the NVA app with you!

Find Vision Care Providers
Search for network providers by locations and by number of frames available at $0 out-of-pocket cost.

View Benefits
Fast access to eligibility and plan coverage information.

Access Your ID Card
Simply pull up your ID card image whenever you need it.

Discover the NVA Smart Buyer®
Get the info you need to make smarter buying decisions on eye care and eyewear.

Download on App Store

GET IT ON Google Play

Please Note: Only NVA active main cardholders can access the NVA vision benefits member app. Dependents cannot create their own accounts on the app.

Important Contacts

Coverage	Administrator	Phone	Website
Employee Clinic	CareATC	1-314-314-7434	www.careatc.com
Pharmacy	Express Scripts	1-877-777-8225	www.express-scripts.com
Health Advocate	United Healthcare	Call Number on Back of Medical ID Card	www.myuhc.com
Wellness Program	Wellness Coordinator	314-415-8034	lgonzalez1@parkwayschools.net
Medical (Base Plan)	United Healthcare	1-866-633-2474	www.myuhc.com
Medical (High Deductible Plan)	United Healthcare	1-866-734-7670	www.myuhc.com
Dental Plan (PPO)	Delta Dental	1-800-335-8266 or 1-314-656-3001	www.deltadentalmo.com
Dental Plan (Pre-Paid)	SunLife (Assurant)	1-800-733-7879	www.sunlife.com
Vision	National Vision Administrators (NVA)	800-672-7723 TTY:711	www.e-nva.com
Aetna Medicare Plan	Aetna	1-888-267-2637	www.aetnaretireeplans.com
Anthem Medicare Plan	Anthem	1-833-848-8729	www.anthem.com
Benefits Team	**Title**	**Phone**	**Email**
General Benefits Email			benefits@parkwayschools.net
Deb Nolan	Benefits Coordinator	1-314-415-8049	dnolan@parkwayschools.net
Dawne Trokey	Executive Director of Finance	1-314-415-8060	dtrokey1@parkwayschools.net
Coby Peters	Benefit Specialist	1-314-415-8059	cpeters@parkwayschools.net
Leah Gonzalez	Coordinator, Employee Wellbeing	1-314-415-8034	lgonzalez1@parkwayschools.net

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form, and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don't contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

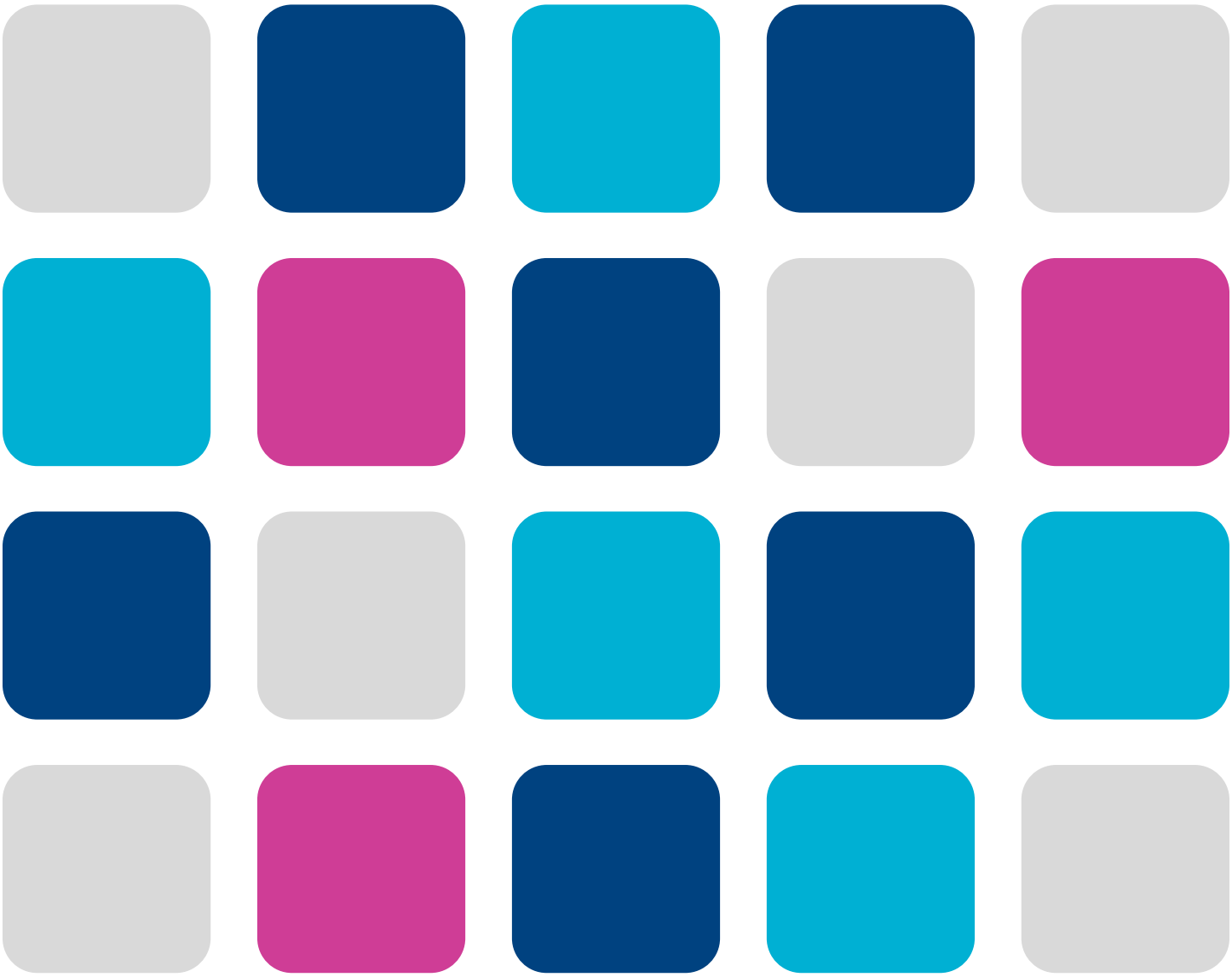
Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

NOTES:



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