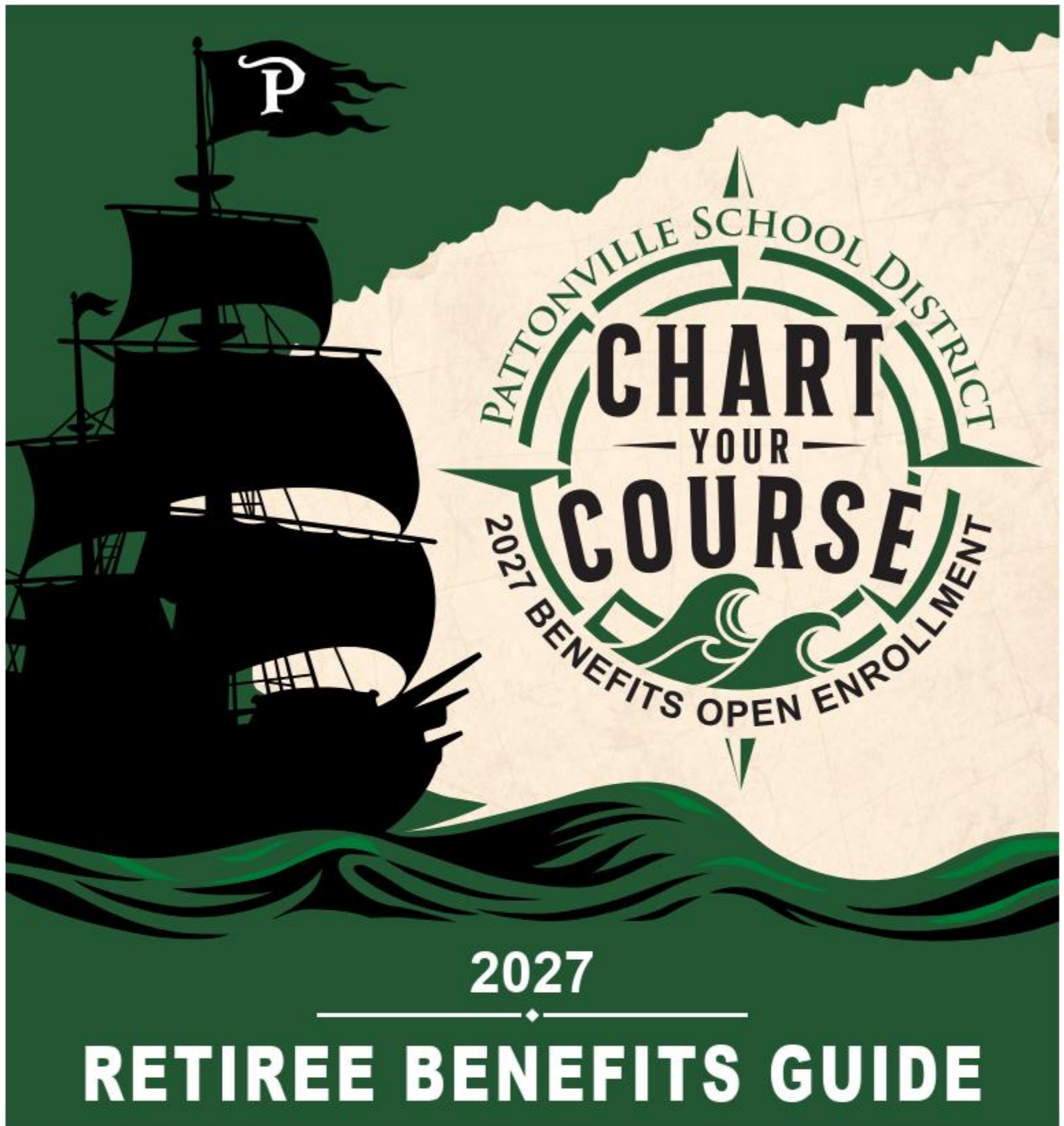




YOUR HEALTH & WELLNESS



Discover Your Benefits

3	Welcome to your 2027 Benefits
4	Summary of 2027 Benefit Changes
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9	Benefit Pricing Guide
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At Pattonville School District, we are proud to offer you and your family a comprehensive range of benefits, supporting your well-being today and in the future. These benefits are a valuable part of your total compensation package. Select the coverage that best meets the needs of you and your family.

The information in this Benefit Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage, and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any express or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact the district's Benefit Coordinator at benefits@psdr3.org.

Welcome to Your 2027 Benefits!

As a valued retiree of the Pattonville School District, you and your family have access to a competitive range of retiree benefits. We are committed to supporting your ongoing well-being by offering programs and coverage that empower you to live healthy, active, and fulfilling lives in retirement.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

Important Dates

Open Enrollment 2027

October 19th – October 30th

Plan Year

January 2027 – December 2027



Please visit the Pattonville benefits website for more information and details of benefits. benefits@psdr3.org



Summary of 2027 Health and Dental Benefit Changes

Health Insurance Plan Changes

- **Elimination of Health Reimbursement Arrangement (HRA):**
 - Effective January 1, 2027, the District-funded HRA will be eliminated.
- **Updates to Out-of-Pocket Costs:**
 - The Standard and Platinum Plans will have adjustments to deductibles and certain out-of-pocket costs, including physician copays and prescription drug tiers.
- **Gold Plan Deductible Structure:**
 - Shift from non-embedded to an embedded deductible structure, allowing individual family members to meet lower individual deductibles.

Premium Changes

- **Platinum Plan:** Retiree-only coverage increases \$75/month.
- **Standard and Gold Plans:** Retiree-only coverage increases \$25.
- **Dependent coverage:** Modest increases on some plans and lower premiums on other plans. Please review premiums on page 9 closely.

Key Information & Resources

- **Unchanged Services:** Preventive and routine care providers remain unchanged.

Guidelines for Retiree Benefits

The Retiree guidelines below are subject to change. For current guidelines, please visit our website (<https://www.psdr3.org/staff/benefits>) and review the Retiree Benefits Guide and pricing.

Retiree Insurance Coverage

Retirees who qualify for benefits under the state retirement system may continue participating in Pattonville School District's group medical, dental, and vision insurance plans. Retirees have a one (1) year special enrollment period, beginning on the date last employed by the District, to elect or return to coverage in accordance with RSMo 169.050.

Retirees are encouraged to visit the Pattonville Benefits webpage for the most up-to-date information on their available benefits and coverage options.

New Retiree Enrollment

Retirees who wish to enroll in Pattonville'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 Pattonville's coverage within one (1) year from the date last employed by the District.

Enrollment Process

1. **Notify Human Resources of your planned retirement date.** Once the District receives notification of your retirement, the Benefits Department will email information about continuing group insurance coverage, including enrollment instructions and required forms.
2. **Complete the required enrollment forms and submit payment.** To avoid a lapse in coverage, all required forms must be submitted and payment received in accordance with the District's enrollment requirements.
3. **Coverage effective date.** Retiree coverage begins on the first day of the month following the date employee benefits end, provided all required forms have been submitted and payment has been received.

Adding Dependents

Retirees may add a spouse or dependent child(ren) under age 26 to their coverage during the one (1) year special enrollment period from the date they were last employed by the District, subject to the District's enrollment requirements and applicable plan provisions.

Returning to Coverage Within One Year

Retirees who choose not to continue their medical, dental, and/or vision coverage at the time of retirement may return to Pattonville's group coverage within one (1) year from the date they were last employed by the District, in accordance with RSMo 169.050.

This one-year period provides an opportunity for retirees to enroll in coverage they initially declined or to return to coverage after choosing not to continue it at retirement.

Enrollment Restrictions After One Year

Once the one (1) year period from the date the retiree was last employed by the District has expired, a retiree who cancels an individual coverage type (medical, dental, or vision) will no longer be eligible to re-enroll in that specific coverage type.

This restriction applies to future open enrollment periods and qualifying life events (QLEs).

Retirees should carefully consider their coverage decisions, as declining or canceling a coverage type after the initial one-year period may result in the permanent loss of eligibility to re-enroll in that coverage.

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 contact the Benefits Department.

Any changes must be processed and received by the district no later than 5 business days before the first day of the month that you wish to drop coverage.

Eligibility

If you currently have dependents on your plan, eligible dependents include:

- Your legal spouse;
- Children under the age of 26, regardless of student, dependent, or marital status;
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

For details on eligibility and when your benefits begin and end, refer to your summary plan documents.

Changing Coverage During the Year

After your one (1) year special enrollment period from the date you were last employed by the District has expired; you generally may not change your retiree benefit elections unless you experience an unanticipated qualifying life event (QLE).

Examples of an unanticipated qualifying life event may include:

- Birth or adoption of a child
- Marriage
- Divorce
- Death of a spouse or dependent
- Your spouse experiencing an unplanned loss of employer-provided health benefits

Please note: A spouse voluntarily terminating employment or electing to retire does not constitute an unanticipated loss of employer-provided benefits and does not qualify as an unanticipated qualifying life event under this policy.

Reporting an Unanticipated Qualifying Life Event

If you experience an unanticipated qualifying life event, please contact the Pattonville Benefits Department as soon as possible.

Written notice must be provided to the Benefits Department within 30 days of the qualifying life event. Failure to provide timely notice may result in the loss of your opportunity to make a coverage change. In that case, you will generally need to wait until the next annual open enrollment period, unless you experience another qualifying life event that permits a change.

The Benefits Department will provide information about the required documentation and enrollment process for your specific qualifying life event.

Declining Coverage During the Special Enrollment Period

If you do not elect any coverage during your one (1) year special enrollment period, you will not be eligible to enroll in Pattonville's retiree group coverage after that period expires. This includes future annual open enrollment periods and qualifying life events.

We encourage you to carefully consider your coverage options before the special enrollment period ends, as declining coverage may result in the permanent loss of eligibility to enroll.

Annual Open Enrollment

Pattonville 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 at www.psd3.org/staff/benefits 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 regulations. 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.

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 on the 2nd day of each month from one (1) bank account which can be set up by the retiree. Payment is for the current month of coverage.

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.

When a scheduled ACH payment is returned by a retiree's bank, we 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.

Medicare Eligibility

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

Pattonville offers fully insured Medicare Advantage plans and a Medicare Supplement 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 Pattonville. Enrollment is optional and provided as a courtesy for retirees who prefer this type of Medicare coverage.

Retirees will be notified of Medicare options during annual Open Enrollment, and Plan materials can be found at www.psdr3.org/staff/benefits.

Pattonville 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.

If a retiree becomes eligible for Medicare and terminates their medical coverage through Pattonville, an eligible spouse or dependent child may be offered up to 36 months of COBRA continuation coverage, in accordance with applicable COBRA requirements.



Benefit Pricing Guide for the 12-Month Plan Year January 1, 2027 - December 31, 2027

Open Enrollment October 19 – October 30, 2026

This year's Open Enrollment is a **PASSIVE** enrollment. All insurance coverages in which you are currently enrolled **will continue automatically** into the new policy year *unless* you choose to update your insurance. *Please review the Key Updates to the 2027 plan provided in this packet.*

Please note - medical and dental plan prices have changed!

All premiums are paid by Direct Debit. Your monthly debit will be the sum of all premiums. Premium direct debits were previously debited on the 10th of the month.

Beginning in January 2027, premiums will be debited on the second banking business day of each month (unless it falls on a weekend and then it will be Monday).

This is by design to allow your retirement check to be direct deposited the last day of the month and provide a day to confirm receipt prior to the insurance debit.

Anthem	Retiree	Spouse	1 Child	Children	Family
Platinum PPO	\$975	\$1,795	\$1,500	\$1,575	\$2,200
Standard PPO	\$875	\$1,560	\$1,300	\$1,365	\$2,025
Gold HDHP	\$750	\$1,375	\$1,100	\$1,175	\$1,750
Delta Dental	Retiree	Spouse	1 Child	Children	Family
Premier PPO	\$50	\$95	\$123	\$130	\$170
EPO	\$25	\$42	\$46	\$48	\$67
UHC Vision	Retiree	Family	The Hartford	\$7,500*	\$15,000
	\$5.56	\$16.09		\$19.65	\$39.30
			*retired in summer of 1995 or earlier		

The following plans are associated with **Medicare**.

If you are choosing not to enroll in one of the traditional health plans offered by Pattonville and are age 65 but want to remain part of the Pattonville group, you may choose one of these plans.

IMPORTANT: To enroll or inquire about either of these plans, please use the contact information below.

United Healthcare Medicare Advantage Medicare Replacement Plan	UHC.com/Medicare 877-714-0178 Telephone Enrollment Only
TransAmerica Medicare Supplement MediGap or Supplement Plan	TransAmerica.com 800-797-2643 Mail correct enrollment form to: Transamerica Life Insurance Company P.O. Box 189 Cedar Rapids, IA 52406
Blue MedicareRX Plan Part D Prescription Drug Plan	Anthem.com 866-830-0296 Call Anthem's First Impressions Welcome Team at 866-830-0296 to request a pre-enrollment kit including application (to MAIL back)

**Pattonville Retiree Insurance Carriers
2027 Plan Year**

Carrier Names	Group Number	Phone	Website
Anthem (medical)	L08555	833-639-1635	www.anthem.com
Express Scripts (prescription)	PATTONV	800-282-2881	www.express-scripts.com
CareATC (clinic)		918-779-7400	www.careATC.com
Delta Dental (dental)	PPO 3720-3000 EPO 3720-2000	800-355-8266	www.deltadentalmo.com
UHC Vision (vision)	00742869	800-638-3120	www.myUHC.com
The Hartford (life insurance)	402274	800-523-2233	www.thehartford.com
United Healthcare Medicare Advantage	Missouri 13762 Non Missouri 13763	877-714-0178	www.retiree.UHC.com
TransAmerica Medicare Supplement		800-749-6983	www.transamerica.com
Blue MedicareRX (PDP)		866-830-0296	www.anthem.com

If you wish to view your current benefits or you are planning to update your coverage we offer the following methods of access:

For enrollment or billing questions please contact:

- **Pattonville Benefits Coordinator**
- 11097 St Charles Rock Rd.
- St. Ann, MO 63074
- **benefits@psdr3.org**

Reviewing Insurance Benefit Options:

- **psdr3.org/staff/benefits**
 - Insurance Benefits
 - Links & Phone numbers to all carriers
 - Guides, Brainshark w/ Audio, Medical plan summaries
 - Medicare Supplemental Policy Information

Accessing your Benefits:

- Sydney Health (Anthem) app
- Express Scripts mobile app
- CareATC app

Eligibility

For details on eligibility and when your benefits begin and end, refer to the summary plan documents.

<https://www.psdr3.org/staff/benefits>

You may also enroll eligible dependents for coverage.

Eligible dependents include:

- Your legal spouse
- Your children up to age 26
- Your dependent children over age 26 who are incapable of self-care because of a disability and who rely on you for support

Choose Carefully!

The benefit elections you make during your initial enrollment or open enrollment remain in effect for the entire plan year. Changes can only be made during the next open enrollment period or if you experience a qualified life event, as defined by the IRS.

You have 30 days from the date of the qualifying event to request changes to your benefit selections. To make changes, please contact the Benefits Department and provide any required documentation within the allowed timeframe.

Examples of Qualified Life Events Include:

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

Change in Medicaid/CHIP Status (60 Days from QLE to Request a Change)

Change in Status	Copy of Medicare or CHIP Award Letter or Notice
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For more detailed information please refer to the retiree guidelines pages of this guide (pg 5-8)

Enrollment



Open enrollment for 2027 is October 19th through October 30th

Before You Enroll

Enrollment Instructions:

- Review Your Options: Carefully review the coverage choices in this guide to select the best fit for you and your family.
- Verify Eligibility: Ensure all dependents meet the necessary eligibility requirements before enrolling.
- Understand Costs: Review plan costs and payroll deductions associated with your elected benefits.
- New Retirees: Contact the Benefits Department at benefits@psdr3.org to enroll or ask questions.
- Existing Retirees: Enrollment is passive unless you want to make plan changes. To update your coverage, contact the Benefits Department.
- Learn More: Scan the QR code or visit our benefits website for detailed plan documents and resources.

Benefits
Department

Visit | <https://www.psdr3.org/staff/benefits>
Email | benefits@psdr3.org



Medical | Anthem

Your health is the foundation of a productive and happy life. That's why we offer comprehensive medical plans designed to meet your needs and support your well-being. Through Anthem, you have access to a medical plan that provides valuable coverage and benefits.

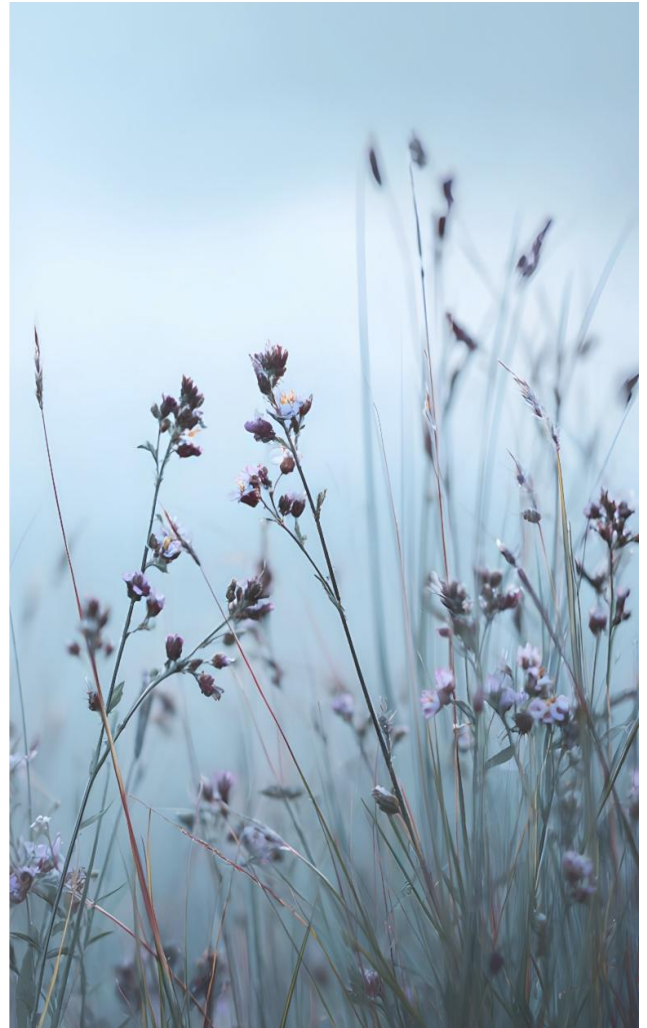
Virtual Care | [Anthem Virtual Care Online](#)

Access a healthcare provider through virtual visits within minutes for convenient care. This benefit offers a quick and easy alternative to in-person visits for the diagnosis and treatment of over 80 common health conditions.

Virtual care for HSA members are covered for free when the virtual care is access via the Sydney app.

In-Network vs. Out-of-Network Providers

In-network providers have agreed to set rates with your medical plan, so you pay less when you use them. Out-of-network providers don't have these agreements, which usually means higher costs for you, and sometimes limited or no coverage. Using in-network providers helps you save money and makes it easier to manage your care. Be sure to check Anthem's website to find in-network doctors, hospitals, and specialists near you.



Finding an
In-Network
Provider

Visit | [anthem.com](https://www.anthem.com)
Call | 833-639-1635
Mobile App | Sydney Health
Group Number: L08555



Medical Plan Summary | Anthem

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

	Platinum PPO	Standard PPO	Gold HSA
	Blue Access Choice	Blue Access Choice	Blue Access Choice
	In-Network	In-Network	In-Network
Calendar Year Deductible			
Individual / Family	\$500 / \$1,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)			
Individual / Family	\$3,000 / \$6,000	\$4,500 / \$9,000	\$3,000 / \$6,000
	You Pay	You Pay	You Pay
Preventive Care	No charge	No charge	No charge
Primary Care Physician	\$25	\$35	Deductible
Specialist	\$50	\$70	Deductible
Chiropractic	\$25	\$35	Deductible then 50%
Urgent Care	\$75	\$100	Deductible
Emergency Room	\$200	\$300	Deductible
Lab & X-ray	Deductible	Deductible	Deductible
Hospitalization	Deductible	Deductible	Deductible
Diagnostic Imaging (MRI/CT)	Deductible	Deductible	Deductible
Pharmacy Express Scripts			
Rx Deductible	N/A	N/A	Medical Deductible Applies
Retail Rx (Up to 30-day Supply)			
Tier 1 / Tier 2 / Tier 3 / Tier 4	\$10 / \$40 / \$70 / \$160	\$10 / \$40 / \$70 / \$160	Deductible
Mail Order (Up to 90-day Supply)			
Tier 1 / Tier 2 / Tier 3 / Tier 4	\$20 / \$80 / \$140 / \$320	\$20 / \$80 / \$140 / \$320	Deductible





Track your health and benefits with the Sydney Health app

Check out these app features



SydneySM Health helps manage your health and benefits anywhere. Scan the QR code on this flyer to download the app. Then from *Menu*, access these highlights:

My Plans



Benefits & Coverage

Select your plan for details like your deductible, out-of-pocket maximum, and coinsurance (your percentage of the costs).

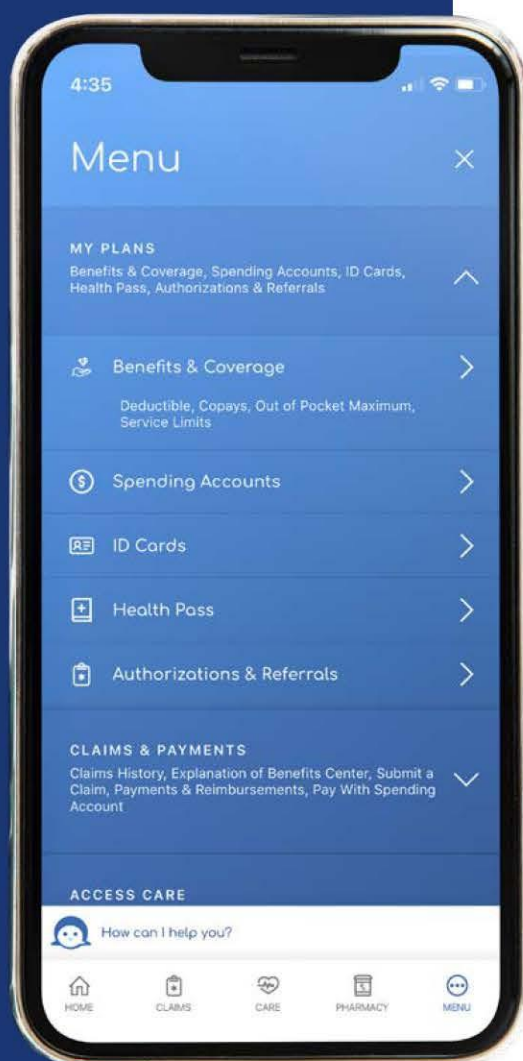


ID Cards

Access your digital member ID card.

Claims & Payments

Visit the Explanation of Benefits Center, submit a claim, and see your claims history.



Access Care



Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network. Filter by gender, languages spoken, or location. You can also compare costs.



Virtual Care

Assess your symptoms with the Symptom Checker, or talk to a doctor through chat or video.



Community Resources

Find organizations that offer no- or low-cost programs to help with food, transportation, and childcare.



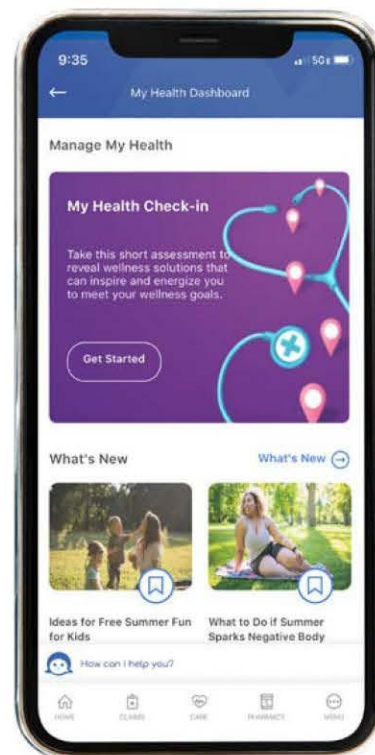
My Health Dashboard

Find health news, health and wellness tips, and personalized action plans. You can also sync your fitness tracker.



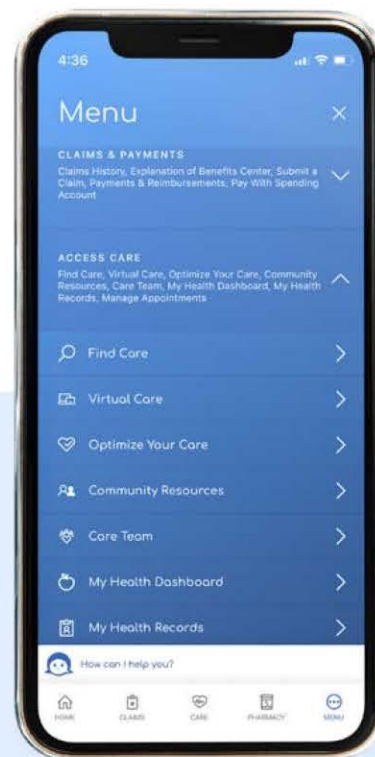
My Health Records

With a single profile, you can view, download, and share your family's health histories and electronic medical records.



Support

Choose **Live Chat** to chat online, **Contact Us** to talk directly to an Anthem Blue Cross and Blue Shield representative, and **Message Center** to send and receive messages. You can also find answers to common questions.



Download the Sydney Health app



Scan the QR code to [download the Sydney Health app](#).

You can also sign up at anthem.com/register to access most of the same features from your computer.



[In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.]

[Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.]

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and AMGP Georgia Managed Care Company, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc. and Anthem HealthChoice HMO, Inc. In these some counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI) underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in PDS policies.

Medical | Compare Care, Reduce Costs

Care in the right setting saves money. The chart below compares examples of average costs in different care settings for a range of common health conditions. **Please note these are estimated average costs only.**

Example of Care Options to Consider	Start Here	24/7 Virtual Visits	Convenience Care	Urgent Care	Emergency Room
	Primary Care Provider (PCP) The provider may know you best.				
Example Average Cost	In-Person: \$ Virtual: \$ or less	\$	\$	\$	\$
Allergies	X	X			
Bladder infection/UTI	X			X	X
Broken Bone				X	X
Bronchitis	X	X		X	
Chest Pain					X
Cough	X	X	X		X
COVID-19 Symptoms	X			X	
Earache	X	X	X		
Fever	X	X	X		
Flu/Common Cold	X	X	X		
Migraine/Headache	X	X			
Muscle Ache/Sprain	X		X		
Pinkeye	X	X	X		
Shortness of Breath					X
Sinus Infection	X	X	X		
Skin Rash	X	X	X		
Sore Throat	X	X	X		
Stomach Pain (Nausea, Vomiting, Diarrhea)	X			X	
Yeast Infection	X	X			

X Shows which suggested care option to use for the common conditions listed above.

This information is for general, illustrative purposes only and is not medical advice or a substitute for your doctor's care.

Always consult an appropriate health care professional about what is right for you. In an emergency, call 911 or go to the nearest emergency room.

Virtual primary care refers to services with a provider via video, chat, email or audio-only, where allowed by state law. These services are available only if the provider is licensed in the state where the member is located at the time of the appointment. Virtual primary care is not for emergency or life-threatening conditions and should not be used in those situations. Services may not be available at all times, in all locations, or for all members. Certain prescriptions may not be available and other restrictions may apply. *Data rates may apply. †The reduced rate for 24/7 virtual visits may change at any time. Check your official health plan documents to see what services and providers are covered by your plan.

Understanding Your Medical Options

PPO vs. QHDHP

Pattonville School District offers three medical plans through Anthem to meet a variety of health needs and budgets. To choose the best plan for you and your family, it's important to understand how each plan works.

	PPO Preferred Provider Organization	QHDHP Qualifying High-Deductible Health Plan
Monthly Premiums	Higher	Lower
At First	You pay fixed copays for most medical services and prescriptions, which do not count towards your deductible but do count toward your out-of-pocket maximum.	You pay 100% of medical and prescription costs until you meet your annual deductible. After that, the plan pays covered costs in full for the rest of the plan year, up to any applicable limits.
Preventive Care	Covered 100% in-network.	Covered 100% in-network.
Meeting Your Deductible	You will pay the full discounted cost of services until the deductible is met.	You will pay the full discounted cost of services until the deductible is met.
Out-of-Pocket Maximum	Plan pays 100% once reached.	Plan pays 100% once reached.
Health Savings Account	Not Available	Available

Using a **PPO** Plan (Example)

Syd felt anxious and used the insurance website to find an in-network psychiatrist. After paying a copay for the visit and a generic prescription, both copay payments counted toward Syd's out-of-pocket maximum. The PPO plan was the best choice, helping Syd save money and receive quality care with regular specialist visits.

Using a **QHDHP** Plan (Example)

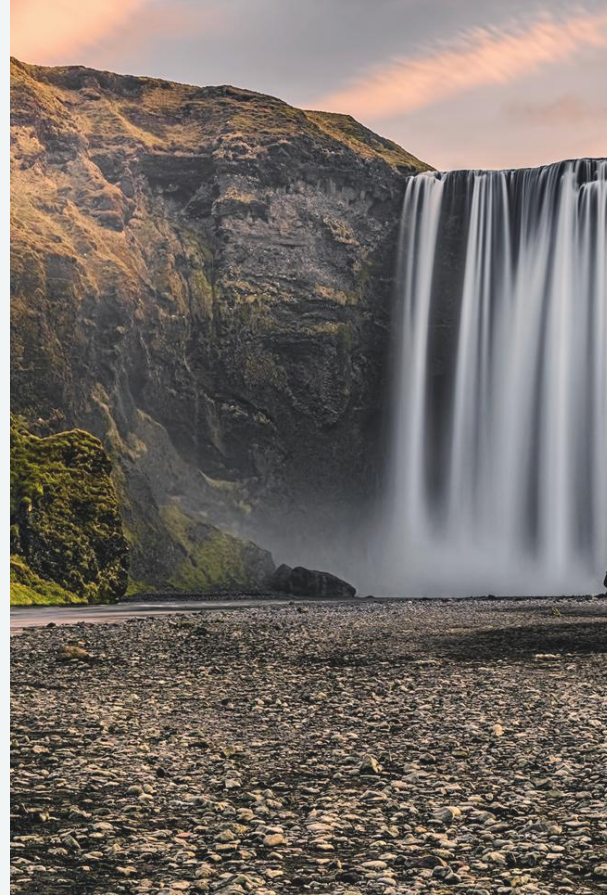
Taylor rarely visits the doctor, but after experiencing a fever and chest congestion, Taylor went to an in-network urgent care clinic. Since Taylor was enrolled in the HSA, his deductible applied to his urgent care visit, which he paid for using his HSA funds. Taylor was able to accumulate funds for his HSA account through lower payroll premiums.

Dental | Delta Dental of MO

Maintaining good dental health is an important part of your overall wellness. The dental plans, offered through Delta Dental of MO, provides coverage to help you and your family maintain healthy teeth and gums. Regular dental care can prevent cavities, gum disease, and detect early signs of other health conditions.

Why Dental Benefits Matter

- **Preventive Care Saves You Money:** Routine cleanings and exams help catch problems early, reducing the need for costly treatments later.
- **Protect Your Smile and Confidence:** Coverage for restorative services like fillings, crowns, and root canals helps you maintain a healthy, attractive smile.
- **Support for Orthodontic Care:** Whether for children or adults, orthodontic benefits help correct alignment issues that can improve oral function and appearance.
- **Access to Quality Care:** Our extensive network of dental providers ensures you receive high-quality care close to home.



How to Maximize Your Dental Benefits

- Schedule regular preventive visits to avoid costly dental problems.
- Use in-network providers to maximize your coverage and reduce out-of-pocket costs.
- Keep track of your annual maximum to plan major treatments effectively.
- Take advantage of orthodontic benefits early to support long-term oral health.

Finding an
In-Network
Provider

Visit | www.deltadentalmo.com
Call | 800-335-8266
Mobile App | Delta Dental Mobile App
Group Number:
High Plan 3720-1000 Low Plan 3720-2000



Dental Plan Summary | Delta Dental of MO

The table below summarizes the key features of the dental plans. Please refer to the official plan documents for additional information on coverage and exclusions. **Cleanings are not included in the calendar year max.**

	Delta Dental PPO Plan			Delta Dental EPO Plan		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Calendar Year Deductible						
Individual	\$50	\$50	\$50	\$5 Copay Per Visit	N/A	N/A
Family	\$150	\$150	\$150			
Calendar Year Benefit Maximum						
Per Individual	\$1,500	\$1,500	\$1,500	\$1,000	N/A	N/A
	You Pay			You Pay		
Preventive Care	0%	0%	0%	0%	N/A	N/A
Basic Services	10%	20%	20%	30%	N/A	N/A
Major Services	40%	50%	50%	50%	N/A	N/A
Orthodontia						
Children (Up to Age 26)	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,000	N/A	N/A
Adults	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,500	50% up to a lifetime maximum benefit of \$1,000	N/A	N/A

Use in-network dental providers to avoid balance billing and unexpected charges. Check the provider directory or contact Member Services for help finding a dentist.

Vision| United Healthcare

Clear vision is essential for daily life and work performance. The vision plan, offered through United Healthcare, provides coverage for routine eye exams, lenses, frames, and contact lenses. Regular eye exams can also help detect early signs of health conditions such as glaucoma and diabetes.

Why Vision Benefits Are Important

- **Early Detection of Eye Conditions:** Routine eye exams can identify vision changes and health issues before symptoms appear.
- **Cost Savings on Eyewear:** Receive allowances for frames, lenses, and contact lenses, helping you afford quality eyewear.
- **Improved Quality of Life:** Corrective lenses help reduce eye strain, headaches, and improve focus, enhancing your comfort and productivity.
- **Access to a Wide Network:** Choose from numerous in-network providers for convenient care and maximum benefits.
- **Regular Updates:** Benefit frequency limits ensure you have access to updated prescriptions and the latest lens technologies.

Tips for Using Your Vision Benefits

- Schedule your eye exam within the recommended frequency to maintain optimal eye health.
- Explore frame and lens options within your allowance to find the best fit for your style and needs.
- Consider contact lenses if preferred, with coverage included in your plan.
- Use in-network providers to maximize your benefits and minimize out-of-pocket expenses.

Finding an
In-Network
Provider

Visit | www.myuhc.com
Call | 800-638-3120
Mobile App | UnitedHealthcare
Group Number: 00742869



Vision Plan Summary| United Healthcare

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.

	Vision Plan	
	In-Network	Out-of-Network
	You Pay	Reimbursed Up to
Exam	\$10	Up to \$40
Materials	\$10	See Below
Lenses		
Single Lenses	\$10	Up to \$40
Bifocals	\$10	Up to \$60
Trifocals	\$10	Up to \$80
Frames	\$130 Allowance then 30% Off	Up to \$45
Covered Services - Contacts in Lieu of Frames/Lenses		
Contacts - Medically Necessary	Covered in Full	Up to \$210
Contacts - Elective	Up to \$125	Up to \$125
Calendar Year Benefit Frequency		
Exams	Once Every 12 Months	
Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Contacts	Once Every 12 Months	
Vision Monthly Premium		
Employee Only	\$5.56	
Employee + Family	\$16.09	



CareATC Health & Wellness Center



Your health center benefits

- **Affordable care.** No copay or deductible is required, except a **\$35 office visit fee** for HDHP plan members receiving non-preventive services.
- **Comprehensive care.** Primary and preventive care, treatment for illness or injury, and chronic disease management.
- **Quick, easy appointments.** Schedule through the CareATC mobile app, online, or by phone.
- **Free lab work and generic medications** provided during your visit.
- **Less wait time, more face time** with your medical provider.
- **No insurance billing.**

Area Health Centers

Claymont Health Center

15421 Calyton 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



Three Ways to Schedule:

 CareATC Mobile App  www.careatc.com/patients  314.314.7434



Show Me
The App!



Medicare Options

The following plan options are associated with Medicare and are only available to those eligible for Medicare. Once enrolled in the below plan(s), changes in plan election will not be allowed until the following open enrollment period. If you are choosing not to enroll in one of the traditional health plans offered by Pattonville and are age 65 but want to remain part of the Pattonville group, you may choose one of these plans.

United Healthcare Medicare Advantage Plan

The UHC Group Medicare Advantage is a Medicare Advantage PPO Plan with a Medicare contract. To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in the defined Service Area list in the full benefit summary. You have the "choice" to visit any doctor within the Medicare Complete Network without referrals. However, this option also includes coverage for out of network benefits. Please contact UHC for complete details.

Transamerica Medicare Supplement Plan

The Transamerica Medicare Supplement Plan is another option for Retirees. Premiums are based on age and billed directly to you. When you contact Transamerica to enroll you will need to inform them that you are with the Pattonville School District. If you choose to enroll in this plan, please consider also enrolling in a Part D Prescription Drug Plan.

Blue MedicareRx (PDP)

The Anthem Blue MedicareRx Plan is another option for Retirees. Monthly premiums are billed directly to you. When you contact the First Impressions team to enroll you will need to inform them that you are with the Pattonville School District. This is a Part D Prescription Drug Plan.

IMPORTANT: To enroll or inquire about any of these plans please use the contact information below

United Healthcare Medicare Advantage Medicare Replacement Plan	UHC.com/Medicare 877-714-0178 Telephone Enrollment Only
TransAmerica Medicare Supplement MediGap or Supplement Plan	TransAmerica.com 800-797-2643 Mail correct enrollment form to: Transamerica Life Insurance Company P.O. Box 189 Cedar Rapids, IA 52406
Blue MedicareRX Plan Part D Prescription Drug Plan	Anthem.com 866-830-0296 Call Anthem's First Impressions Welcome Team at 866-830-0296 to request a pre-enrollment kit including application (to MAIL back)

6 Medicare mistakes to avoid

With millions of enrollees, Medicare is a massive federal health program that touches nearly everyone. If you're not enrolled or planning on joining, you probably have a loved one or friend taking part. If so, then you've already heard some of the horror stories about problems, oversights, and miscalculations that leave folks with too little coverage, or painfully high premiums. With so much bad information out there, I'd like to outline a few of the common mistakes and pitfalls I've seen clients struggle with over the years.

1. Missing your initial enrollment period

For most enrollees, Medicare eligibility begins at the start of the month in which you turn 65. Guidelines provide for a 7 month enrollment window; 3 months prior, the month you turn 65, and 3 months after. If you miss that enrollment period, you may have to wait until the next General Enrollment period, and you may have to pay a penalty.

Enrolling in Medicare is usually an opt-in process. You can visit www.SSA.gov to find the local Social Security Office and enroll in person, or you can [enroll online at www.SSA.gov](http://www.SSA.gov). [Please note however](#), that if you're receiving your Social Security retirement check when you first become eligible for Medicare, you'll be enrolled and receive your Medicare ID card automatically.

2. Enrolling in Medicare Part B when you don't need it

If you have group health coverage through your employer (or through your spouse's employer), and that employer has 20 or more workers, you can delay enrollment into Medicare Part B until employment ends. In this scenario, there are no penalties or waiting periods for delayed enrollment. And, since there's a monthly premium for Part B, you could be paying for something you don't need (if you have both Part B and employer group health coverage). [Go here](#) for details.

3. Failing to enroll in Part B when you have COBRA or retiree medical coverage

Even though COBRA looks like a straightforward continuation of your former employer's group health plan, federal rules make COBRA coverage a secondary payer to Medicare. This means you could have a significant, uncapped out-of-pocket exposure for any medical bills if you haven't signed up for Part B. You may have penalties and a waiting period for enrollment, too.

Retiree plans have a variety of rules and regulations that make one-size-fits-all guidance impossible. For many retiree plans, Medicare is your primary payer. For some, Medicare isn't even necessary. When planning for your retirement, reach out to your employer HR department or union health and welfare fund administrator as early as possible to review their written rules and guidelines. It's a good idea to review coverage costs against market alternatives such as Medi-Gap plans, too.

4. Skipping Part D coverage

Part D drug insurance plans should not be viewed as optional coverage. If you miss your initial enrollment opportunity, you'll not only have a late entry premium penalty when you join, but you'll have to wait until next January for coverage. With all the expensive break-through drugs coming into the market, you could have some difficult choices to make if you're without a Part D plan.

5. Choosing cheap over good when buying Medicare insurance products

Maintaining our health in retirement should be one of our most important goals. When we're choosing Medicare insurance plans, we need to put quality ahead of cost. Medicare Advantage plans with insufficient provider networks or high out-of-pocket exposures, drug plans with small formularies and poor customer service, MediGap plans from insurers with questionable financial stability are all hard-to-spot deficiencies that can leave us regretting our buying decisions.

6. Trying the D-I-Y approach

In taxes, law and finance, we know that well informed decisions are easier when we hire a professional CPA, attorney or financial planner. In much the same way, utilizing a Medicare specialist insurance broker will prove helpful and keep you out of do-it-yourself traps. Your broker is your advocate and will support their recommendations with well-reasoned explanations, plain language consumer resources, and transparent cost information. Look for the same professional criteria from your broker as you would the rest of your advisor team—experience, reputation, transparency and knowledge.

Getting the best available health coverage out of your Medicare enrollment shouldn't be like peeling an onion, with layer after layer of tear-inducing effort that leaves you with nothing but a mess to clean up. Plan ahead, know your rights, rely on your experts and you'll find the right path to great coverage in your retirement.



Kevin J. Guss, GBA

Vice President & Practice Leader,
Private Client Benefit Services

314.594.2717 | Kevin.Guss@MarshMMA.com

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Additional Resources | Mental Health Support

If you believe you need help right away – for yourself or a loved one – call 911 or use the emergency numbers below.

Substance Use Helpline – 1-800-662-4357

If you feel that you or a loved one are experiencing signs of addiction, call the confidential helpline to get support, guidance on treatment options, help finding a network provider and answers to your questions.

National Domestic Violence Hotline – 1-800-799-7233 or Text START to 88788

Get help with crisis intervention and referrals to local services for victims of domestic violence and those calling on their behalf.

National Suicide Prevention Lifeline – 988

If you or someone you know is in suicidal crisis or emotional distress, get emergency help right away. Contact the lifeline 24/7, free and confidential support for people in distress and prevention and crisis resources for you or loved ones.

The Crisis Text Line – Text HOME to 741741

The Crisis Text Line is a free resource available 24/7 to help you connect with a crisis counselor.



Glossary

Balance Billing: When an out-of-network provider bills you for the difference between their charge and what your insurance pays.

Benefit Year: The 12-month period during which your benefits and coverage apply.

Claim: A request for payment that you or your provider submits to your insurance for covered services.

Coinsurance: The percentage of costs you pay for a covered service after meeting your deductible (e.g., you pay 20%, insurance pays 80%).

COBRA: A federal law allowing you to continue your health coverage temporarily after leaving a job, usually at your own cost.

Copayment (Copay): A fixed fee you pay for a covered service, like \$20 for a doctor visit.

Deductible: The amount you pay out-of-pocket for covered services before your insurance starts to pay.

Dependent: A family member, such as a spouse or child, who is eligible for coverage under your plan.

Eligibility: The requirements you must meet to qualify for benefits, such as employment status or hours worked.

Explanation of Benefits (EOB): A statement from your insurer explaining what was covered, what you owe, and how claims were processed.

FSA (Flexible Spending Account): A pre-tax account you can use to pay for eligible health care expenses.

HMO (Health Maintenance Organization): A plan requiring you to use in-network providers and get referrals for specialists.

HSA (Health Savings Account): A tax-advantaged savings account for medical expenses, available with high-deductible health plans.

Imputed Income: The taxable value of non-cash benefits that an employer provides to an employee. Instead of receiving cash, employees receive certain benefits—like health coverage for a domestic partner, employer-paid life insurance above IRS limits, or personal use of a company car—that the IRS considers as income for tax purposes. This means the value of these benefits is added to the employee's taxable wages.

In-Network: Providers or facilities that have a contract with your insurance plan to offer services at negotiated rates.

Member Services: The department you contact for help with your benefits and coverage questions.

Network Directory: A list of in-network providers and facilities covered by your plan.

Open Enrollment: A set period each year when you can sign up for or make changes to your benefits.

Out-of-Network: Providers or facilities not contracted with your insurance plan, often resulting in higher costs.

Out-of-Pocket Maximum: The most you will pay in a year for covered services, after which insurance pays 100%.

Outpatient Care: Medical services you receive without being admitted to a hospital overnight.

Premium: The amount you pay (usually monthly) to have health insurance coverage.

Prior Authorization: Approval your insurer requires before certain services or medications are covered.

PPO (Preferred Provider Organization): A plan that offers more flexibility to see any provider but costs less when using in-network providers.

Telehealth: Health care services you can access remotely via phone or video.

Waiting Period: The time you must wait after becoming eligible before your benefits begin.

Notice of Non-discrimination

Applicants for admission or employment, students, parents of elementary and secondary school students, employees, sources of referral and applicants for employment, and all professional organizations that have entered into agreements with the Pattonville School District are hereby notified that the District does not discriminate on the basis of race, color, ethnicity, national origin, sex, age, pregnancy, disability, or any other characteristic protected by law in admission or access to, or treatment or employment in, its programs and activities. In addition, the District provides equal access to the Boy Scouts of America and other designated youth groups.

Any person having inquiries concerning the District's compliance with the laws and regulations implementing Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), the Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973 (Section 504), Title II of the Americans with Disabilities Act of 1990 (ADA) or the Boy Scouts of America Equal Access Act, is directed to one of the District Compliance Coordinators listed below, who oversee the District's efforts to comply with the laws and regulations implementing the laws and regulations cited above.

The District has established grievance procedures for persons unable to resolve problems arising under the statutes above. One of the District's Compliance Coordinators will provide information regarding those procedures upon request. Any person who is unable to resolve a problem or grievance arising under any of the laws and regulations cited above may contact the United States Department of Education's Office for Civil Rights, Region VII, 1 Petticoat Lane, 1010 Walnut Street, Suite 320, Kansas City, MO 64106; phone (816) 268-0550

The District's Compliance Coordinators are:

David Besgrove, Chief Human Resources Officer (for employee or visitor-related concerns) and
Dr. Tori Cain, Assistant Superintendent of Student Services (for student-related concerns)

Pattonville School District
11097 St. Charles Rock Road
St. Ann, MO, 63074
Telephone: (314) 213-8500

MARSH AGENCY

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