Employee Benefits Guide 2021

COVID-19 Related Relief

Please note that, due to the COVID-19 pandemic, agency-issued guidance impacting Plan participants is constantly evolving. If you have concerns under the Plan with respect to your coverage or meeting an applicable deadline due to the national emergency concerning the COVID-19 outbreak, please contact Talent Department to determine if relief may be available to you.

Important Contacts

BENEFIT CONSULTANT

HYLANT

CMSD Employee Benefits Help Desk
1111 Superior Ave.
Cleveland, OH 44141
Monday-Friday 8:30am-4:30pm
benefits@clevelandmetroschools.org

Note: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Contact	Phone	Website
Medical	Medical Mutual of Ohio	1-800-228-6472	https://member.medmutual.com
Medical	Aetna	1-877-238-6201	https://www.aetna.com
Medical	UH Choice EPO Plan	1-877-230-0992	www.myuhcchoice.com
COVID-19	CMSD COVID-19 Hotline	216-838-WELL	
Prescription Drug	CVS/Caremark	Available Soon	www.caremark.com
Flexible Spending Account	Medical Mutual/FlexSave	1-800-525-9252	https://member.medmutual.com
Wellness Incentive	Hylant	N/A	Email: CMSDHRA@Hylant.com
Employee Assistance Programs	Center for Families & Children	216-241-EASE (3273) 1-800-521-3273	www.easeatwork.com
Dental	MetLife Dental	1-800-942-0854	https://www.metlife.com
Vision	United HealthCare	1-800-638-3120	https://www.myuhcvision.com
Life / AD&D	MetLife Insurance	1-800-638-6420, prompt #1 then prompt #2	www.metlife.com/mybenefits

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If you (and/or) your dependents have Medicare or will become eligible for Medicare In the next 12 months, a Federal law give you more choices about your prescription Drug coverage. Please see page 31 for more details.

HIGHLIGHTS FOR 2021

Your benefits are an important part of your total rewards at Cleveland Metropolitan School District. Please take the time to review this Benefits Guide to assist you in making informed enrollment decisions that are the best fit for the health, wellness and financial needs of you and your family.

CVS/Caremark Replaces Express Scripts Effective 1/1/2021

We are excited to announce a new partnership with CVS/Caremark as the prescription benefits manager (PBM) for all three CMSD health plan options effective January 1, 2021. While we understand change can cause concern, we are doing everything possible to minimize the impact this will have on CMSD health plan participants.

Your new CVS/Caremark plan will be ready to use on January 1, 2021. All prescriptions filled at retail on or after January 1, 2021 should be processed under your new CVS/Caremark benefits. All mail order prescriptions on or after January 1, 2021 will be processed by Caremark rather than Express Scripts.

All mail order prescriptions with remaining refills will automatically be transferred to CVS/Caremark for service on or after January 1, 2021. If you have valid mail order refills available, you will not need to get a new prescription from your physician,

If you have a prescription with refills available, you may continue to fill that prescription at the retail pharmacy. This includes 90-day maintenance prescriptions that you are having filled at CVS currently.

You will receive a new prescription only member ID card. In the mail in mid-December. For those on the Aetna or UH Choice programs, this will replace your Medical Mutual Express Scripts card and should be presented at the pharmacy when you have a prescription filled on or after January 1, 2021. For Medical Mutual (MMO) medical plan participants, you will now have a separate card for your pharmacy benefits. This will be in addition to your MMO medical card. You will continue to use your MMO card for medical services like doctor's office visits or hospital services, but you will need to use your new CVS/Caremark card for any prescription fill.

With this change there is a small amount of change in what drugs fall into what prescription tier. If you have a prescription that will be impacted by changing tier, you will receive communication from CVS/Caremark in December. You will then need to consult with your physician to determine if there is another prescription alternative that will work for you. If your physician and you agree on an alternative, your physician will need to write a new prescription for the newly prescribed medication.

Please look for further announcements regarding this change leading up to January 1, 2021 including the dedicated CVS/Caremark customer service support phone number and signing up for access to your CVS/Caremark account through the CVS/Caremark website and/or mobile app.

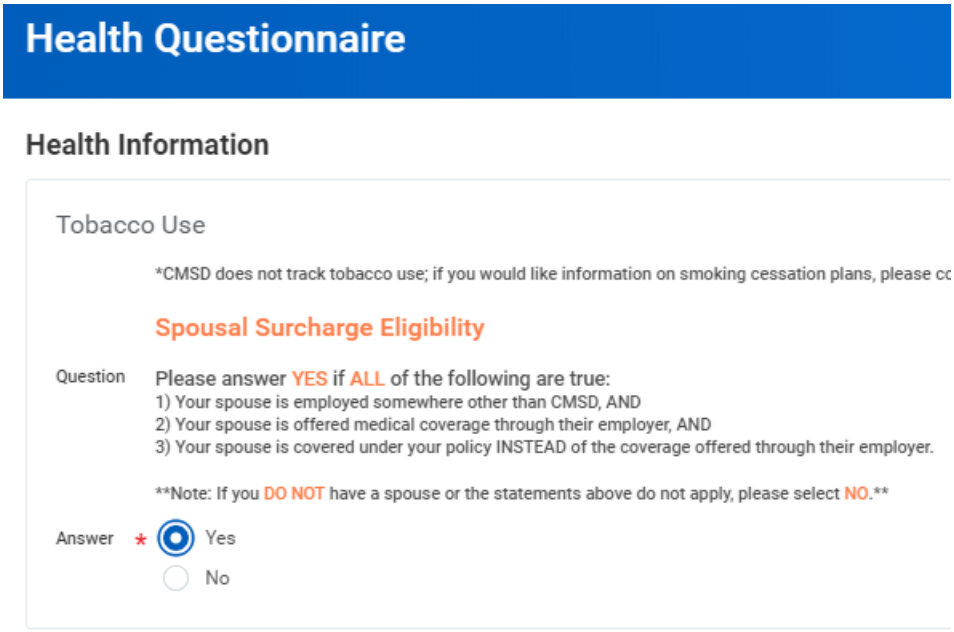
Spousal Surcharge

During your enrollment process, you will be presented with the same opening screen as last year. This screen is setup to allow you to make changes to your spousal surcharge election information.

The spousal surcharge is required when ALL the following are true:

1. Your spouse is employed somewhere other than CMSD, AND
2. Your spouse is offered medical coverage through their employer, AND
3. Your spouse is covered under your policy INSTEAD of the coverage offered through their employer.

The benefits in this document are effective: January 1, 2021 – December 31, 2021



Voluntary Life Simplified Underwriting

During Open Enrollment, you will have the opportunity to review your voluntary life insurance election and increase the amount of coverage subject to simplified underwriting. If you elect to enroll in the program or increase your benefit amount, you will be asked to complete a short questionnaire. This provides an opportunity to review the amount of coverage you have in place without the more extensive Statement of Health process typically required by MetLife. You will receive confirmation of the increase or declination once your simplified underwriting responses are received and reviewed.

Please see page 14 of this guide to review the Simplified Underwriting questions.

ENROLLING IN BENEFITS

OVERVIEW

OPEN ENROLLMENT

NOVEMBER 1, 2020 – NOVEMBER 30, 2020

This Benefits Guide provides an overview of your benefit options and additional information to help you make your enrollment decisions. The 2021 Open Enrollment is offered to employees enrolled in the Cleveland Metropolitan School District Employee Benefit Plans. While everyone is encouraged to take this once a year opportunity to review their annual elections, please note the specific instructions below.

IMPORTANT:

- *Flexible Spending Account (FSA) enrollment elections do NOT automatically renew and must be RESELECTED for 2021.*
- *If you previously opted-out of benefits, you must opt-out every year to receive the opt-out payment.*
- *If you are currently enrolled in the medical, drug, dental, vision or life insurance plans, and are satisfied with your current benefit coverage you do NOT need to take any action regarding those plan elections.*
- *If you wish to make any changes in your coverage or plan elections, you must login and make the change.*

ENROLL: MAKING YOUR ELECTIONS

YOU MUST USE WORKDAY TO ENROLL OR MAKE BENEFIT CHANGES

Notifications and instructions for Open Enrollment are sent through the Workday Inbox. You can access the 2021 Open Enrollment, which provides detailed information about the medical, drug, dental, vision, flexible spending accounts (FSA), and life insurance options that are available to you.

ACTION ALERT:

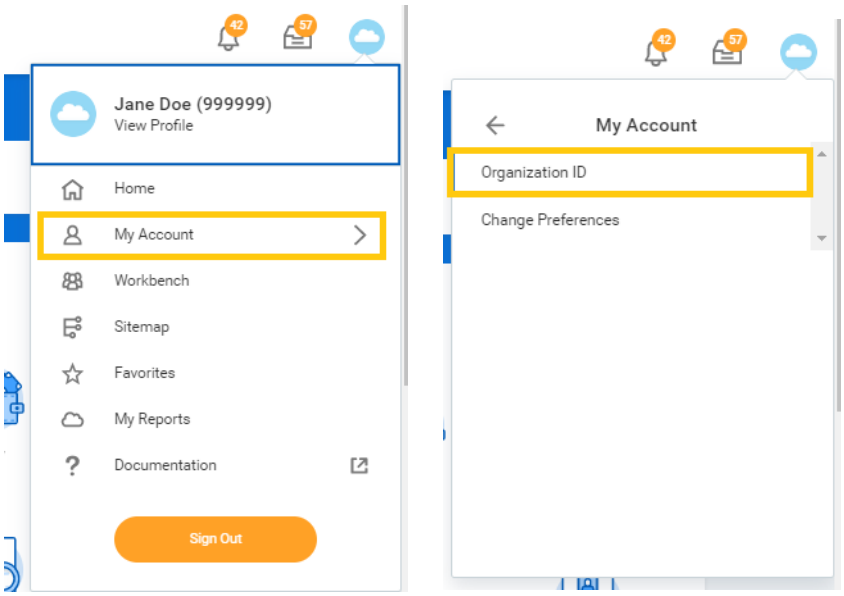
Choose your benefits wisely! After the enrollment deadline, benefit elections cannot be changed or canceled until the next enrollment period unless a qualifying event occurs.

SPOUSAL SURCHARGES

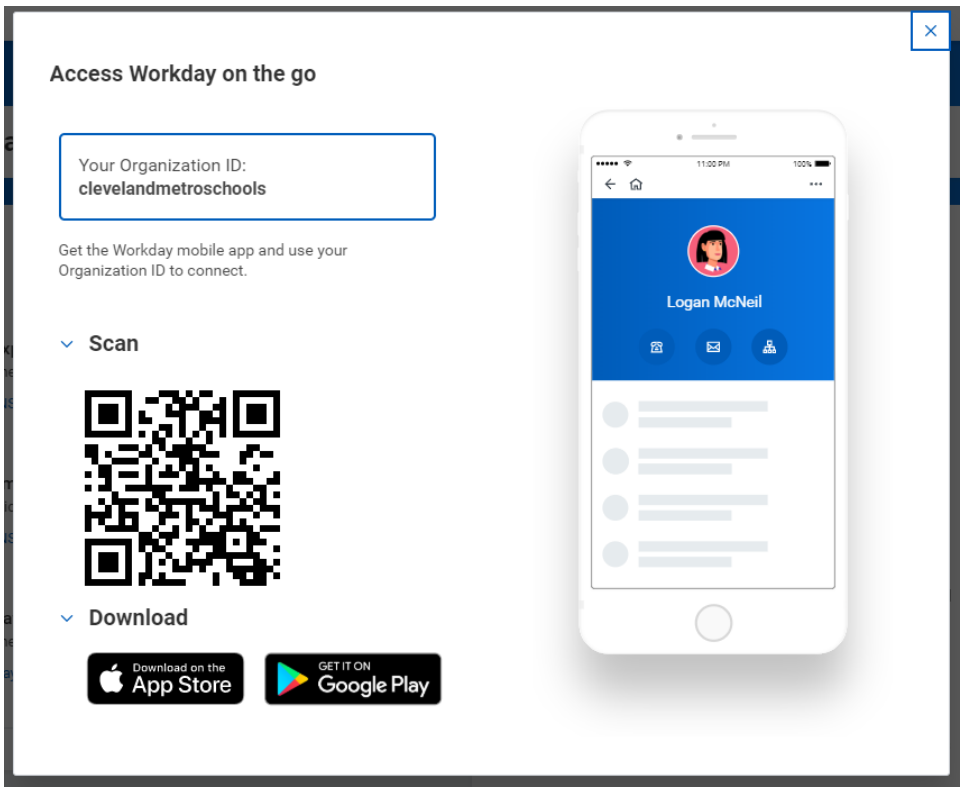
If an employee enrolls his/her spouse in the District's health insurance program and that spouse is eligible to participate in a group health insurance sponsored by his/her employer or retirement plan, the bargaining members will pay an additional monthly premium contribution for family coverage. However, upon the spouse's enrollment in his/her employer's healthcare plan or retirement plan, the additional contribution will not apply if that plan will provide primary coverage for the spouse and the District's plan will provide secondary coverage. **Spousal surcharge amount is identified on the premium rate page.**

HOW TO ACCESS WORKDAY MOBILE APP TO MAKE YOUR ELELCTIONS

1) Log in to Workday and click on the icon in the upper right corner to open the profile dropdown options. Click on ‘My Account’ and select ‘Organization ID’.



2) After downloading the app, use the Organization ID or QR code to access Workday on your smartphone or tablet.

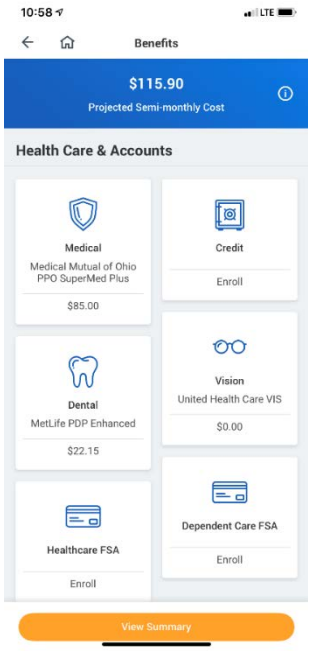


MAKING YOUR ELECTIONS

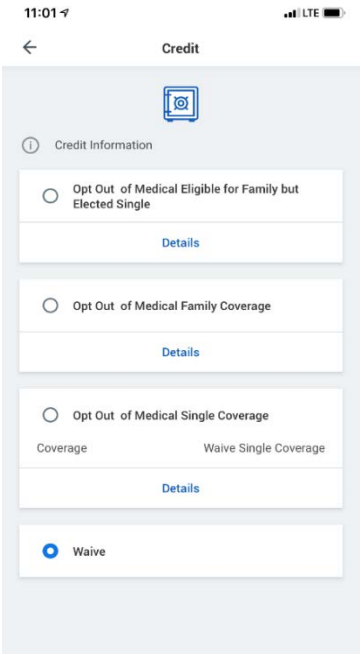
HOW TO BEGIN

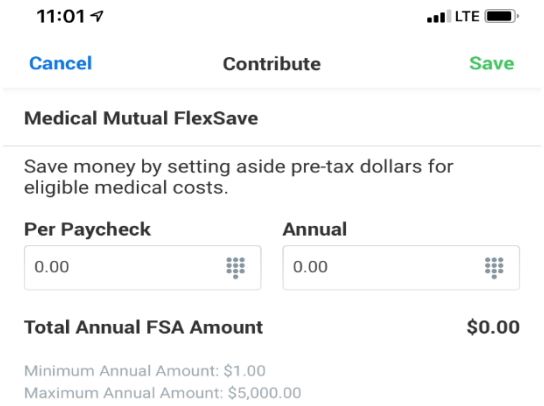
Use Workday on an internet enabled device, computer or app to view/enroll/change/add/delete/opt-out. You can enroll at home, work, or through any other internet enabled computer. The system is available 24 hours per day, 7 days per week November 1, 2020-November 30, 2020.

- Make changes or updates to benefits plans directly from your phone!



- Easy access to Opt-Out options and FSA enrollments





OPT-OUT INFORMATION

You **MUST USE WORKDAY** to enroll and **ELECT** “Credit-Opt-Out” in the medical coverage option each year to qualify for the Health Care Waiver.

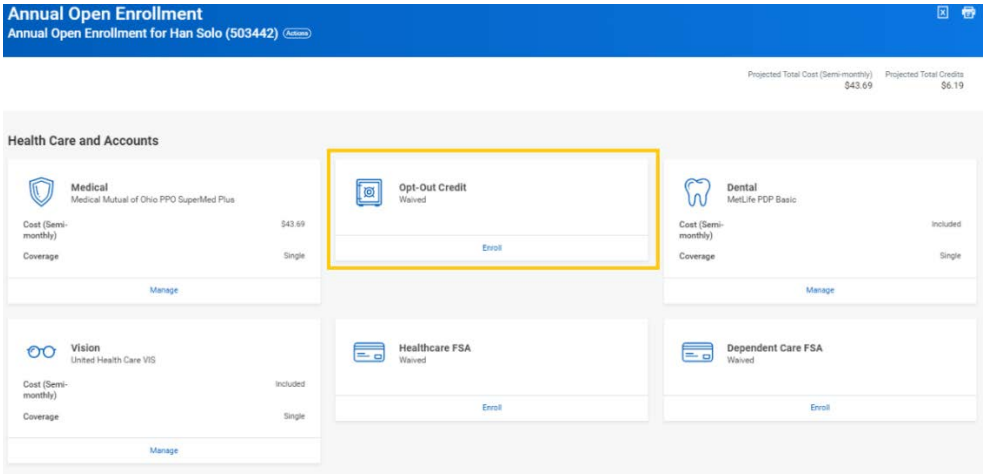
You **MUST** submit proof of other medical coverage (coverage not provided by the Cleveland Metropolitan School District).

Opt-Out payments will be included in the second paychecks in April and October 2021.

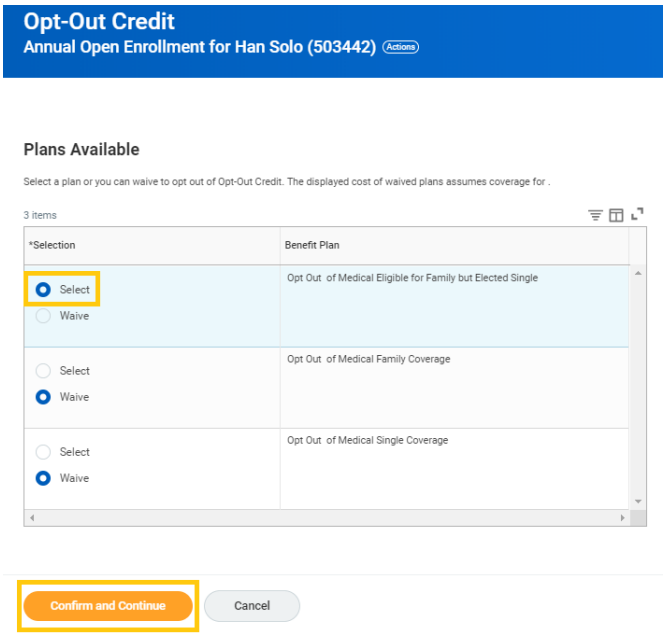
If you wish to waive coverage for your eligible family members and elect single coverage for yourself, you must list your eligible dependents in the dependents section. Please see example below.

How to Opt-Out:

Step 1: Click on the Opt-out Credit option in the enrollment event.

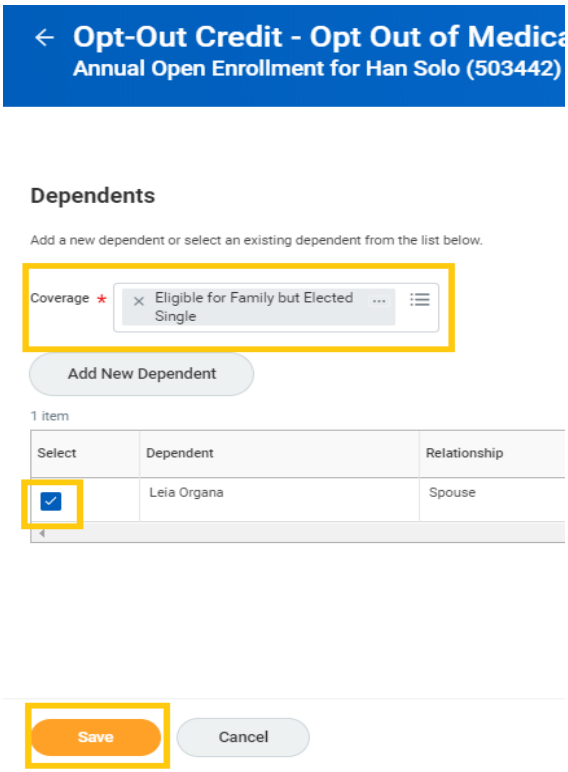


Step 2: Click ‘Select’ on the plan you wish to elect and then ‘Confirm and Continue’.

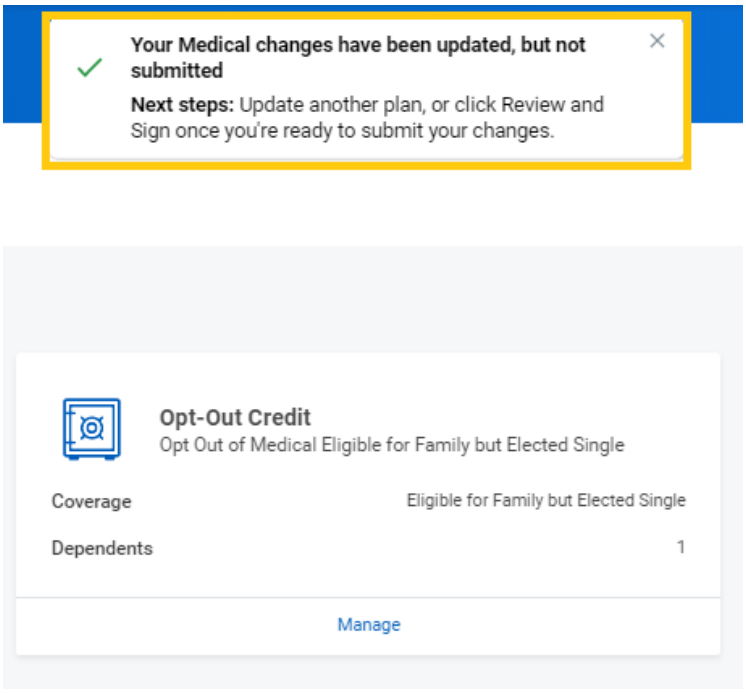


Step 3: Select the coverage type from the drop down menu and click ‘Save’.

- Please note, at least one dependent is required for the Family or Eligible for Family options.



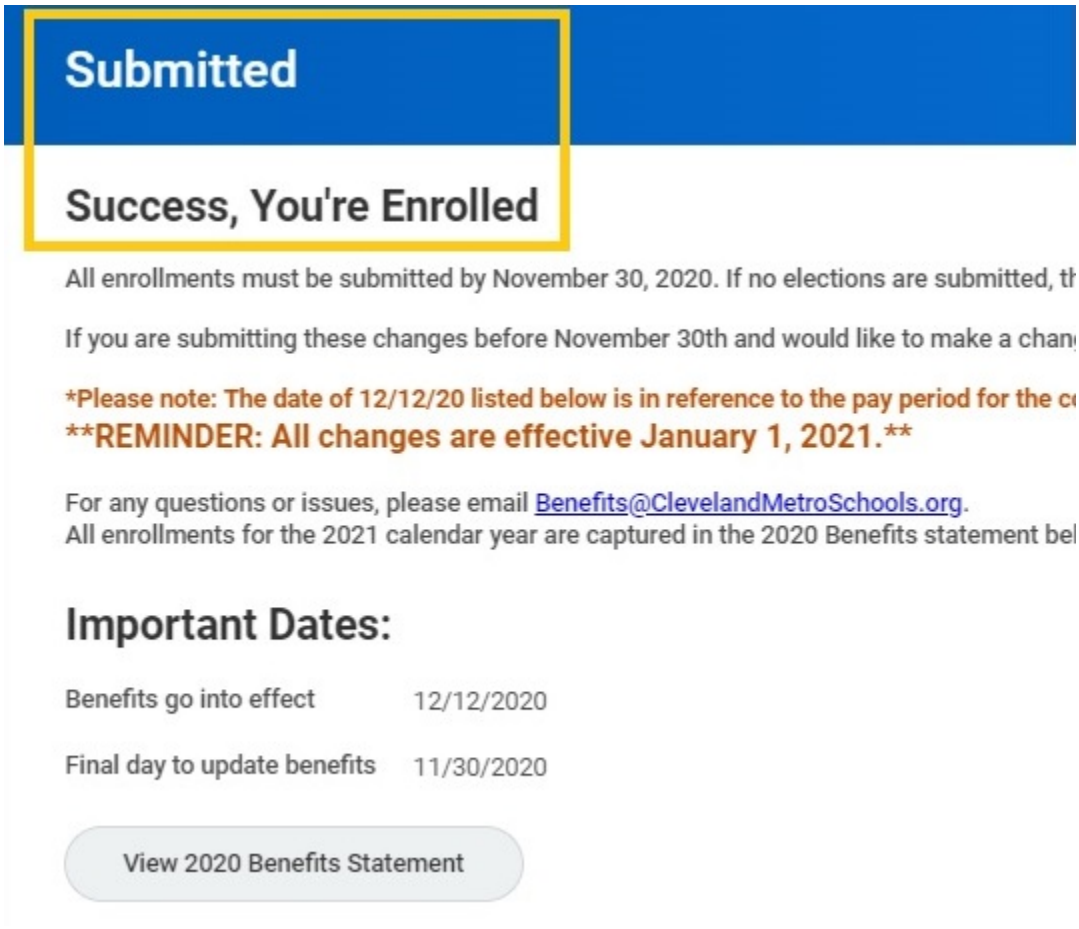
Step 4: When all desired elections have been made, be sure to ‘Review and Sign’ any changes. No changes will be processed if the event is not SUBMITTED.



SUBMITTING YOUR ELECTIONS

A confirmation statement can be viewed, saved or printed once the event has been submitted.

NOTE: If two married employees both work for the District, neither employee can opt-out of coverage and receive the Health Care Waiver. Opt-Out guidelines may vary per union agreement. Refer to your labor agreement for specific Opt-Out guidelines.



AFTER YOU HAVE ENROLLED

A confirmation statement will be displayed to verify your benefit elections. Please print a copy for your records.

ASSISTANCE

If you need help or have questions email benefits@clevelandmetroschools.org.

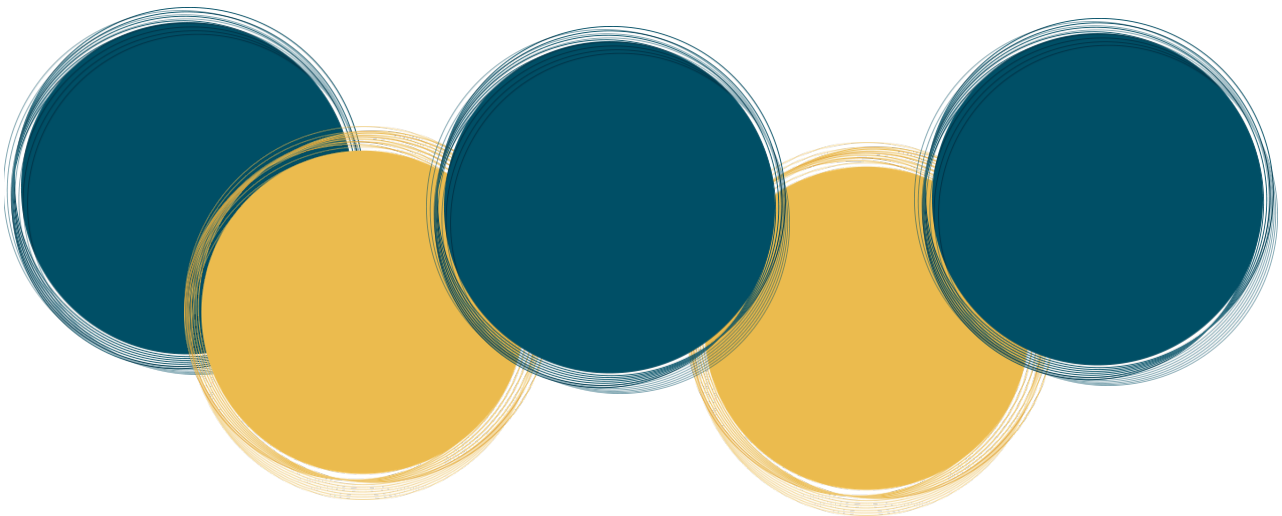
OPEN ENROLLMENT SESSIONS

Virtual open enrollment sessions will be scheduled during the open enrollment window. Further information will be provided during the open enrollment process.

MAKING CHANGES DURING THE YEAR

If you experience a qualifying event and need to make changes to your benefits during the year, please follow the instructions below.

- Log into Workday
- Click on Benefits App
- Under “Change”, choose Benefits
- Select your Benefit Event Type
- Enter your Benefit Event Date (example: date of birth of newborn, date of marriage, etc.)
- Be sure to attach a supporting document or the event WILL NOT be processed (example: proof of birth letter, marriage certificate, etc.)
- Click “Submit” at the bottom of the screen and you will be prompted to make your enrollment selections.
- Once the event is completed and submitted, it will be sent to Benefits for approval. If anything is missing, the event will be sent back to you with the option to make the necessary changes.



ELIGIBILITY

As a benefits-eligible employee, Cleveland Metropolitan School District offers a health and welfare program that offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical	√	Up to age 26
Dental	√	Up to age 19 or 23
Vision	√	Up to age 26
Life and AD&D	√	Up to age 21 or 23

*Dental coverages have a dependent child maximum age of 19 (end of month of reaching age 19) or a maximum age of 23 for full-time students (end of month of reaching age 23).

**UHC Medical and Vision plans have a dependent child maximum age of 26 years.

***Dependent Life Insurance is 21 year of age, or 23 if a full-time student.

DEPENDENT VERIFICATION

You may be asked to provide the Benefits Help Desk proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

SPOUSAL COVERAGE

If your spouse is employed or retired and is eligible for medical benefits through their employer, they are eligible for the Cleveland Metropolitan School District's health insurance plan. You will incur a monthly spousal surcharge in addition to your medical coverage contributions/premiums, if you elect to enroll your spouse in the Cleveland Metropolitan School District's health insurance plan. The amount of the spousal surcharge is detailed on the premium rate pages.

NEW HIRE COVERAGE

As a new employee you have 30 days from date of hire to make your benefit elections. It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event. Following enrollment, your coverage is effective the first of the month following 30 days of service.

TERMINATION OF COVERAGE

If employment is terminated, the end date of your benefits is determined by your Collective Bargaining Agreement.

COBRA CONTINUTATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify the Benefits Help Desk of such change(s), **THROUGH WORKDAY**, within the noted days from the event as shown in the below table. Failure to notify the Benefits Help Desk within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. For questions, please see your Benefits Help Desk representative.

Qualifying Event	Timeframe to Notify Benefits*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your Spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

** days from the qualifying event*

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Employees more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov. **For more information please see page 31**.

BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance. Your beneficiary is the person(s) who will receive your life insurance benefits, if/when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct.

If you do not name a beneficiary, your benefits will automatically go to your estate. For additional information contact the Benefits Help Desk.

COST OF COVERAGE SUMMARY

Based upon 24 deductions taken from the first two paychecks of each month (Full Time Employees assigned to work a minimum of 19 hours per week, except members of District 1199 earning $27,040 or less pear year)

	Single-Wellness	Single- No Wellness	Family-Wellness	Family-No Wellness
MEDICAL				
Aetna (including prescription drug plan)	$37.50	$44.70	$85.00	$109.37
UH Choice EP Plan (including prescription drug plan)	$17.50	$25.00	$50.00	$60.00
MMO-SuperMed Plus PPO (including prescription drug plan)	$37.50	$47.87	$85.00	$110.00
Medical Plan Working Spouse Surcharge	N/A	N/A	$50.00	$50.00
DENTAL				
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
VISION				
Vision (United HealthCare)	$0	$0	$0	$0

Based upon 24 deductions taken from the first two paychecks of each month (Full Time District 1199 Employees assigned to work a minimum of 19 hours per week earning $27,040 or less per year)

	Single-Wellness	Single- No Wellness	Family-Wellness	Family-No Wellness
MEDICAL				
Aetna (including prescription drug plan)	$24.38	$32.50	$55.25	$71.50
UH Choice EP Plan (including prescription drug plan)	$11.38	$16.25	$32.50	$55.25
MMO-SuperMed Plus PPO (including prescription drug plan)	$24.38	$32.50	$55.25	$71.50
Medical Plan Working Spouse Surcharge	N/A	N/A	$37.50	$37.50
DENTAL				
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
VISION				
Vision (United HealthCare)	$0	$0	$0	$0

VOLUNTARY LIFE

Below is the cost for the Voluntary Life Insurance coverage. This will provide an additional life insurance benefit for you, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid.

Employee Contributions for Voluntary Life Insurance Coverage											
Age Schedule	< 25	25-59	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	>70
Monthly Rate Per $10,000 of Coverage	$0.26	$0.26	$0.26	$0.35	$0.53	$0.88	$1.23	$2.11	$3.60	$5.62	$8.78

Employee Contributions for Dependent Life Insurance	
Spouse: Monthly Rate Per	
$5,000	$1.35
$10,000	$2.70
Child(ren) Monthly Rate* Per	
$2,500	$0.40
$5,000	$0.80

Reminder: Please make sure to update your beneficiary information in Workday

**Child rate applies regardless of the number of children covered. Children eligible to age 21 or age 23 if a full-time student.*

How to Calculate Voluntary Portable Life Plan Rates:

1. Total amount of life insurance desired. $_____
2. Divide Line 1 by $10,000. $_____
3. Enter rate per $10,000 based on your age from the table above. $_____
4. Multiply Amount in Line 2 by the Rate in Line 3. $_____

Simplified Life Insurance Underwriting during Open Enrollment for 2021!

MetLife is offering an opportunity for you to sign up for life insurance or increase your life insurance amount through simplified underwriting. If your answers to the questions below are all no, you do not need to complete the Statement of Health process during Open Enrollment. If your answer is yes to any of the below questions you must complete the Statement of Health and be approved by MetLife before the change is life insurance occurs.

MetLife Simplified Underwriting Questions

1. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?

2. Are you now receiving or applying for any disability benefits, including workers' compensation?

3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

4. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?

5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:
    a. cardiac or cardiovascular disorder?
    b. stroke or circulatory disorder?
    c. high blood pressure?
    d. cancer, Hodgkins disease, lymphoma or tumors?
    e. diabetes?
    f. asthma, COPD, emphysema or other lung disease?

MEDICAL

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or SBC. You may access a list of participating providers through the carrier's website.

	Aetna		MMO-SuperMed Plus		UH Choice
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	***Network Only**
DEDUCTIBLES	2021		2021		2021
Individual	$0	$250	$0	$250	$0
Family	$0	$500	$0	$500	$0
COINSURANCE					
Plan Pays	100%	70%	100%	80%	100%
You Pay	0%	30%	0%	20%	0%
OUT-OF-POCKET MAXIMUM					
Individual	$0	$2,250	$0	$2,000	$0
Family	$0	$4,500	$0	$4,000	$0
COMMONLY USED SERVICES					
Primary Physician Visit	$20 copay	70% after deductible	$20 copay	80% after deductible	$10 copay
Specialist Visit	$30 copay	70% after deductible	$30 copay	80% after deductible	$25 copay
Preventive Care Services	100% coverage	70% after deductible	100% coverage	80% after deductible	100% coverage
Urgent Care Visit	$35 copay	70% after deductible	$35 copay	80% after deductible	$25 copay
Emergency Room	$75 copay	$75 copay	$75 copay	$75 copay	$50 copay
Diagnostic Labs & X-Rays	100%	70% after deductible	100%	80% after deductible	100%
Hospitalization	100%	70% after deductible	100%	80% after deductible	100%
Mental Health	100%	70% after deductible	100%	80% after deductible	100%
Substance Abuse	100%	70% after deductible	100%	80% after deductible	100%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

***Please refer to your SBC for UHC Choice Out-of-Netowrk coverage when traveling and for students.

PRESCRIPTION DRUGS

PRESCRIPTION DRUGS 30 DAY SUPPLY AT RETAIL PHARMACY	Aetna & MMO	UH Choice
Generic	$5 copay	$5 copay
Formulary	$15 copay	$10 copay
Non-Formulary	$20 copay	$10 copay
Contraceptives	covered	covered

PRESCRIPTION DRUGS 90 DAY SUPPLY AT MAIL ORDER OR 90 DAY SUPPLY AT CVS/CAREMARK	Aetna & MMO	UH Choice
Generic	$10 copay	$5 copay
Formulary	$30 copay	$10 copay
Non-Formulary	$40 copay	$10 copay

CVS/Caremark

Generic Incentive Program: Members will be required to pay the appropriate drug copayment plus the difference in cost between the generic equivalent and brand name drug if a generic equivalent is available. A generic equivalent drug contains the same active ingredient(s) as the brand name drug and work the same way and must meet the same rigorous U.S. Food and Drug Administration for standards of quality, strength, purity and potency. Should a prescription be written with a *Dispensed as Written* (DAW) and a generic is available, members will be required to pay the appropriate drug copayment plus the difference in cost between the generic equivalent and the brand name drug. Mail order prescriptions will automatically be filled with a generic equivalent whenever available unless the brand drug is specifically requested by the member or physician.

Cost Management Programs: Certain high cost drugs may be subject to prior authorization and/or step therapy requiring that generic and lower cost alternative brand therapies are attempted prior to most costly alternatives.

Routine Maintenance Medications: Members must fill all routine maintenance medications through mail order or 90-day script at retail at CVS/Caremark.

Specialty Mail Order: Accredo will help members to manage their specialty prescription needs. Specialty pharmacy involves complex medications that often require special handling. Accredo will not only help to coordinate delivery but serve as a support for the members that utilize specialty prescriptions.

Prudent Rx: Saves plan members money on specialty drugs by maximizing prescription drug copay assistance from pharmaceutical manufactures with coupons. This program is like the SaveOn SP program that was previously in place with Express Scripts.

IMPORTANCE OF A PRIMARY CARE PHYSICIAN (PCP)

YOUR PARTNER IN HEALTH

Primary care doctors may provide you medical care over a long period of time, help you stay healthy, coordinate your care and recommend other providers, such as specialists, when needed.

CHOOSE THE RIGHT PCP

Choosing a doctor is a very important decision requiring care and consideration. Take advantage of the tools and resources through your medical plan such as provider directories for network providers, maps, and quality ratings to research your options. Asking friends, co-workers or relatives is also helpful when selecting a PCP. For information on specific physicians' training, specialties and board certification you can also visit the American Medical Association at www.ama-assn.org.

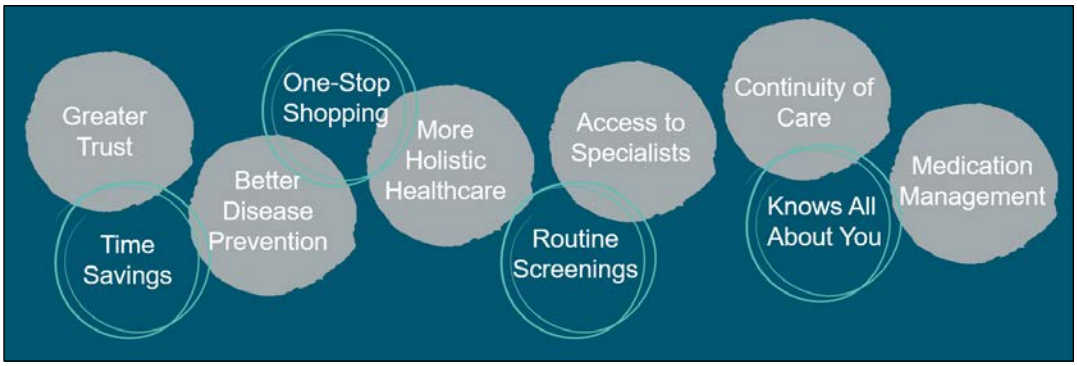
Once you have made your selection, it is important to call your primary care physician for an appointment to establish yourself as a patient. This is a valuable step that may prevent potential wait time in scheduling future appointments.

WHAT DOES A PCP DO?

A primary care provider is your main healthcare provider in nonemergency situations. Starting with preventive care, he or she coordinates the care you need and helps you address health issues before they become a more serious problem. PCPs conduct regular checkups, routine screenings and immunizations, provide patient education, offer advice on preventing disease, as well as overseeing specialty care, lab tests and hospitalization.

BENEFITS OF HAVING A PCP

In addition to the benefits and cost-savings of having an in-network provider, a PCP will help you navigate the healthcare system so you can concentrate on your health. Even if a plan doesn't require you to have a PCP, it's a good idea to choose one. Because of routine tests and regular visits, your PCP will know how to help you stay focused on self-care.



ESTABLISH A RELATIONSHIP WITH YOUR PCP

Having a well-established, trusting relationship with your doctor is crucial to your long-term health, and can also save you money in the long run. Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive.

Tell your doctor about your health history, your family's health history, symptoms, medications and any allergies you have. If you do not share relevant information, your doctor may not ask or may assume there is nothing important he or she needs to know. Withholding information may make it difficult for your doctor to determine the best care route for you to take. The more comfortable you are, the more you'll share — and that can be good for your health in the long run.

Your doctor works hard to keep you healthy, but quality healthcare is a team effort. Make sure to ask questions if you don't understand what your doctor is recommending. This is especially important to do before receiving health services. Not every plan is the same, so it's important to ask questions to avoid confusion and unexpected costs later. If you are confused about anything your doctor recommends, don't be afraid to ask questions.

EMERGENCY ROOM OR URGENT CARE

KNOW WHERE TO GO

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office.

If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

EMERGENCY ROOM

URGENT CARE

The **emergency room (ER)** is equipped to handle life- threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.	**Urgent care centers** are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.
You should go to the nearest ER if you experience any of the following: • Compound fractures • Deep knife or gunshot wounds • Moderate to severe burns • Poisoning or suspected poisoning • Seizures or loss of consciousness • Serious head, neck or back issues • Severe abdominal pain • Severe chest pain or difficulty breathing • Signs of a heart attack or stroke • Suicidal or homicidal feelings • Uncontrollable bleeding	Some examples of conditions that require a visit to an urgent care center include: • Controlled bleeding or cuts that require stitches • Diagnostic services (x-rays, lab tests) • Ear infections • High fever or the flu • Minor broken bones (e.g., toes, fingers) • Severe sore throat or cough • Sprains or strains • Skin rashes and infections • Urinary tract infections • Vomiting, diarrhea or dehydration

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

DON'T PAY MORE IF YOU DON'T HAVE TO:

Convenience Care Clinics are walk-in clinics typically located in a supermarket, pharmacy or retail store, where available. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit copays and/or coinsurance. Convenience care clinics are suitable for non-life threatening immediate care. *Examples include: common infections (ear, bladder, pink eye, strep throat); minor skin conditions, allergies, and more.*

WELLNESS

TAKE CHARGE OF YOUR HEALTH & WELL-BEING

Your health and well-being are very important to us and we want to help keep you and your family healthy. Since we all spend so much time at work, the workplace is an ideal place to provide you with information, encouragement and support for improving your overall well-being. With participation in the CMSD wellness program you may continue your current premiums without increase for 2021. For those that received the credit in 2020, your credit has been carried forward for 2021. New participants in the plan must submit forms no later than 60 days following initial plan eligibility.

BENEFITS AT-A-GLANCE

Who is Eligible?

The Cleveland Metropolitan School District has established a wellness incentive for eligible participants who complete the below list of screenings and Health Risk Assessment.

To qualify the member must have submitted a physician certification of having completed the following activities.

1. **The Physician Certification Form Includes Verification of the Following *(actual results, diagnoses and/or other details of testing or assessment are not to be included):***
   - *Cholesterol Screening*
   - *Glucose Screening*
   - *Blood Pressure Screening*
   - *Body Mass Index (BMI)*
2. **CMSD Health Risk Assessment**

The forms are available on the Employee Benefits webpage at www.clevelandmetroschools.org.

MAINTAINING CURRENT PREMIUM LEVEL

In order to maintain your current premium level, you must complete the above list of activities and submit for verification.

HOW TO SUBMIT YOUR PHYSICIAN CERTIFICATION FORM

***Via Email**:*
CMSDHRA@Hylant.com Hylant

Via US Mail:
Attn: CMSD HRA
6000 Freedom Square Dr., Suite 400
Cleveland, OH 44131

HOW TO SUBMIT A WELLNESS INCENTIVE APPEAL

- Dowload the Wellness Incentive Appeal Request Form from the CMSD Employee Benefits webpage
- Submit the form and supporting documentation to benefits@clevelandmetroschools.org

Appeals must be submitted within 60 days of when you knew or should have known of the event for which the relief is requested.

EMPLOYEE ASSISTANCE PROGRAM

VOLUNTARY, CONFIDENTIAL AND FREE

We are interested in your total well-being. That is why we offer an Employee Assistance Program. This program provides a counseling service that helps you manage problems before they adversely affect your personal life, health and job performance.

http://www.easeatwork.com

216-241-EASE (3273)
or 1-800-521-3273

BENEFITS AT-A-GLANCE

This is a **free** and **confidential** service.

Life can be complicated. There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, daily living services, personal wellness and dependent care resources. If you'd like help handling life's demands, contact the EAP for extra support. Assistance is only a click or phone call away.

PROGRAM DETAILS

3 Face-to-face counseling sessions per incidence and UNLIMITED 24/7telephonic counseling, work/life balance resources

CALL ANYTIME, ANY DAY

Resources are just a phone call away whenever you need them, at no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

VISIT A SPECIALIST

You have three face-to-face sessions with a behavioral counselor available to you and your house-hold members. Call us to request a referral.

ACHIEVE WORK/LIFE BALANCE

If you'd like help handling life's demands, call the EAP for extra support. They can refer to a service in your community.

Create a MyLifeExpert account through the Ease@Work website by taking these steps:

- Click Here: https://mylifeexpert.com/login
- Select 'Sign Up' in the top-right corner
- Enter Company Code: cmsdist
- Provide your District Email Address
- Create your username and follow any final prompts for finalizing your account

ASSISTANCE IS AVAILABLE IN THE FOLLOWING AREAS:

Marital and Family Relationships
Parenting
Teen Resources (dating, bullying, Eating concerns, etc.)
Work-Related Difficulties
Emotional Problems
Alcohol and Substance Abuse
Domestic Violence
Health and Wellness Resources
Personal Financial Management
Legal and Financial Resources and Consulting

And many more!

FLEXIBLE SPENDING ACCOUNT

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as your medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

HOW DOES IT WORK?

You decide how much to contribute to your FSA on a calendar year basis, up to the maximum allowable amount. Your annual election will be divided by 24 or 20 and deducted evenly on a pre-tax basis from each paycheck, along with your benefits, throughout the plan year.

DEBIT CARD AND CLAIM FILING

You will be issued a debit card to access the Healthcare FSA (transactions are to be processed like a credit card; a PIN will not be issued). Simply swipe your card at the provider's office, pharmacy, etc. It is important when utilizing the debit card to still request and keep an itemized receipt. You may receive a letter asking for a copy of the receipt. If you fail to submit the information requested, your debit card may be deactivated. Please contact Medical Mutual FlexSave if this occurs contact information is located on page 4 of this guide.

ACCESSING YOUR ACCOUNT

You may access details of your account to check your balance, review claims history and more through Medical Mutual' s website at www.medmutual.com or by using the Medical Mutual app on your smartphone or tablet.

All participants have a $550 carryover each plan year. Unused contributions over $550 will be forfeited.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A HEALTH FSA

- You cannot take income tax deductions for expenses you pay with your Healthcare FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.
- **You must enroll / re-enroll in the plan to participate for the plan year January 1 to December 31, 2021.**

ANNUAL HEALTHCARE MAXIMUM 2021 CONTRIBUTION LIMITS

$2,750

EXAMPLES OF ELIGIBLE EXPENSES:

Unreimbursed medical expenses (deductibles, coinsurance, copays, etc.)

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts, and eye exams

Lasik eye surgery

Note: Cosmetic services are not eligible for reimbursement

DEPENDENT FLEXIBLE SPENDING ACCOUNT

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed, or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

You may fax, mail or submit your dependent care claim to the carrier for reimbursement online.

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after-school care was $300 for the month, you can only be reimbursed for $200.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as funds are “use it or lose it.”
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (unless you experience certain qualifying life events).
- You may have both a Healthcare FSA and a Dependent Care FSA.
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
  - Name (who received service)
  - Provider name (provider that delivered service)
  - Date of service
  - Type of service
  - Cost of service
- You cannot take income tax deductions for expenses you pay for with your Dependent Care FSA.
- You cannot stop or change your FSA contributions during the year unless you have a change in family status consistent with the change in contributions.
- **You must enroll / re-enroll in the plan to participate for the plan year January 1 to December 31, 2021.**

EXAMPLES OF ELIGIBLE EXPENSES:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

**In order to receive reimbursement for in-home babysitting fees, income must be recorded by the provider.*

For a full list of eligible expenses and requirements, visit www.irs.gov/publications and refer to Publication 503.

DENTAL COVERAGE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or benefit summary. You may access a list of participating providers through Metlife's website.

www.metlife.com/mybenefits 1-800-942-0854

BENEFITS AT-A-GLANCE

	Basic		Enhanced	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Type I—Preventive Services: Oral examinations & cleanings- 2 per plan year Topical fluoride applications (under 14) Bitewing x rays (1 per year) Full mouth x rays (1 every 60 months) Space maintainers for children under age 14	100% of *PDP	100% of **R&C	100% of *PDP	100% of **R&C
Type II—Basic Services: Fillings, simple extractions, endodontics, oral surgery, periodontics, general anesthesia & consultants	80% of *PDP	80% of ** R&C	80% of *PDP	80% of **R&C
Type III—Major Services: Bridges, dentures, inlays, onlays, crown & prosthetics (once every 5 years), crown build-ups, veneers, harmful habit appliance, crown, denture & bridge repair, implants on enhanced plan only	20% of *PDP	20% of **R&C	80% of *PDP	80% of **R&C
Type IV—Orthodontics Up to age 19	20% of *PDP	20% of **R&C	80% of *PDP	80% of **R&C

DEDUCTIBLE	2020 Deductible		2020 Deductible	
Individual	$25	$25	$25	$25
Family	$50	$50	$50	$50

MAXIMUM BENEFIT LIMITS				
Annual Limit: Basic and Major Services	$1,500	$1,500	$2,500	$2,500
Lifetime Limit: Orthodontics	$1,500	$1,500	$2,500	$2,500

*PDP refers to the negotiated fees that Preferred Dentist Program (PDP) dentists have agreed to accept as payment.
**R&C refers to Reasonable & Customary charge based on the lesser: (1) the dentist's actual charge for the same or similar services or (2) the usual charge of most dentists in the same geographical area for the same or similar service as determined by MetLife.

WHICH PLAN FITS: THINKING IT THROUGH…

- Do you visit a dentist for regular cleanings and maintenance?
- What kind of dental expenses will you have next year?
- Do you expect to have certain dental procedures performed?
- Do you have dependents who will require orthodontia services?
- Does your dentist participate in the network?

VISION COVERAGE

The following is a summary of your vision benefits. The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or benefit summary. You may access a list of participating providers through UHC Vision's website.

www.myuhcvision.com 1-800-638-3120

BENEFITS AT-A-GLANCE

Vision Coverage	
In-Network Only	
Eye Exams One exam every 24 months for employees and dependents 19 years of age and older Once every 12 months for employees and dependents under age 19	$0 copay
Lens/Frames One pair every 24 months for employees and dependents 19 years of age or older One pair every 12 months for employees and dependents under age 19	Single Vision $45 copay Standard Bifocals Standard Trifocals Lenticular or Aphakic Lens Frames on display
Contact Lenses One pair every 24 months for employees and dependents 19 years of age or older One pair every 12 months for employees and dependents under age 19 In lieu of spectacle lenses and a frame Cosmetic and medically necessary contact lenses covered in full (up to 4 boxes of disposable lenses)	Contact lenses $45 copay

- Dependent child coverage is provided to eligible children until age 26.
- Full-time employees working 19 or more hours per week are enrolled in vision coverage

When you are ready to use your benefit, simply call the United HealthCare participating provider facility most convenient to you and make an appointment. UHC will request the employee's social security number and patient's date of birth to verify eligibility.