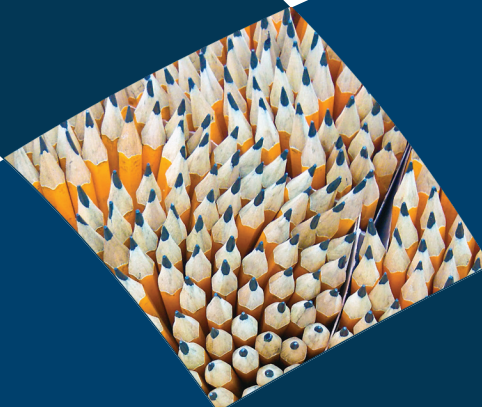




CLEVELAND
METROPOLITAN
SCHOOL DISTRICT

**EMPLOYEE BENEFITS GUIDE
2023**



This booklet is intended as a high level overview and is informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

Important Contacts

BENEFIT CONSULTANT
oswald[®]



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	Anthem	1-833-952-2042	https://www.anthem.com
Medical	UH Choice EPO Plan	1-877-230-0992	http://www.myuhcchoice.com/
COVID-19	CMSD COVID-19 Hotline	216-838-WELL	
Prescription Drug	CVS/Caremark	1-866-249-6175	http://www.caremark.com/
Flexible Spending Account	Medical Mutual/FlexSave	1-800-525-9252	https://member.medmutual.com/
Wellness Incentive	Oswald	N/A	CMSDHRA@oswaldcompanies.com
Employee Assistance Programs	Ease@Work	216-241-EASE (3273) 1-800-521-3273	http://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 gives you more choices about your prescription Drug coverage. Please see page 32 for more details.

Highlights For 2023



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.



All members will receive new ID cards for 1/1/2023

Based upon new legislation, the information health plan payors must include on your ID card is increasing. As a result, you will receive new ID cards this year regardless of whether you make a change in your health care plan or not. Please watch for these cards in the mail shortly before January 1, 2023.



Enrolling In Benefits

Overview

OPEN ENROLLMENT

November 1, 2022 – November 30, 2022

This Benefits Guide provides an overview of your benefit options and additional information to help you make your enrollment decisions. The 2023 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 2023.
- 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 2023 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.

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.

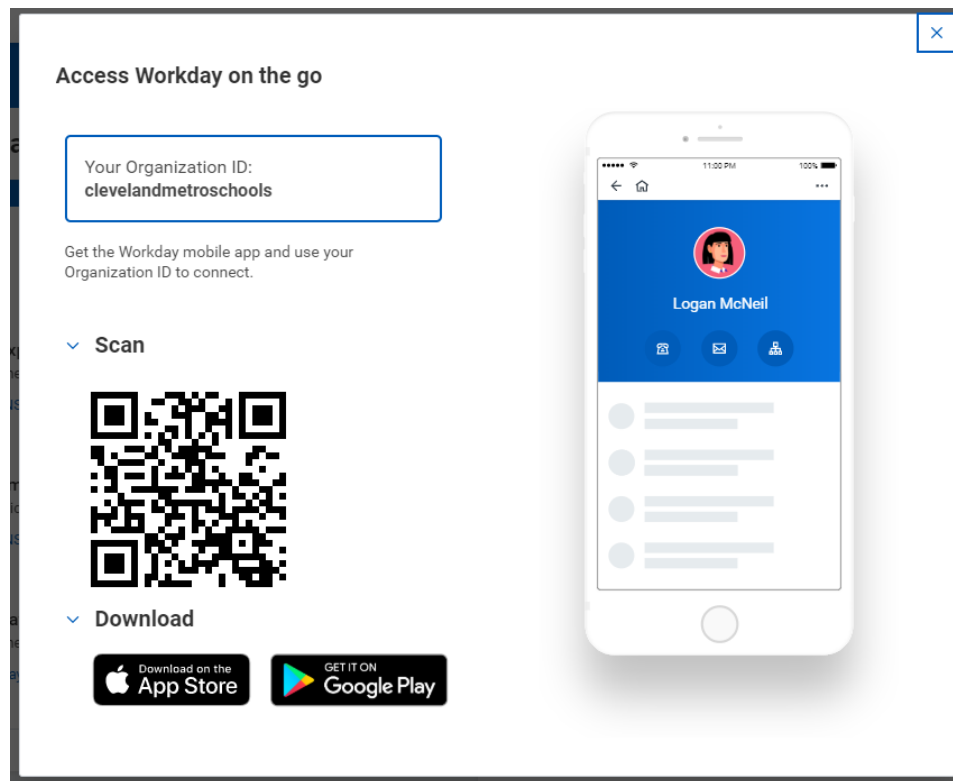
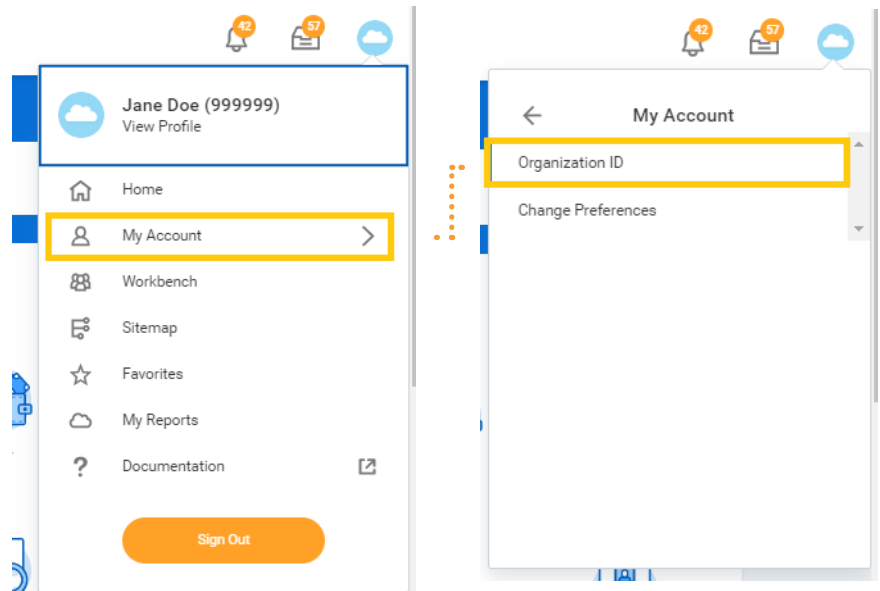
However, upon the spouse's enrollment in his/her employer's healthcare plan or retirement plan, the additional contribution will not apply if that plan will provide primary coverage for the spouse and the District's plan will provide secondary coverage. **Spousal surcharge amount is identified on the premium rate page.**

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.

How to Access Workday Mobile App to Make Your Elections

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'.

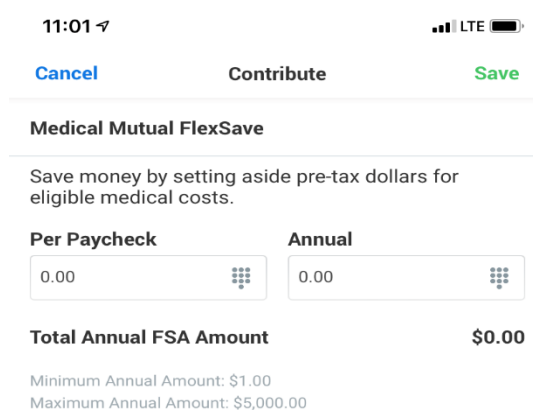
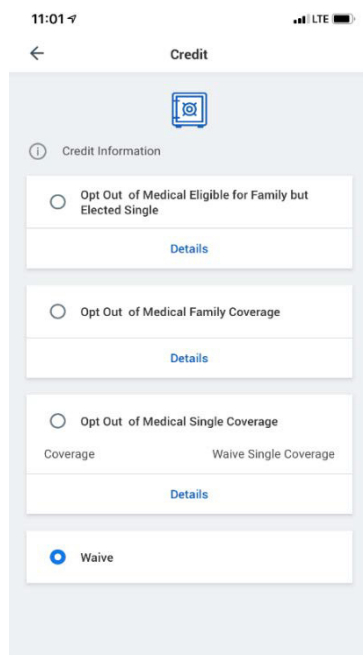
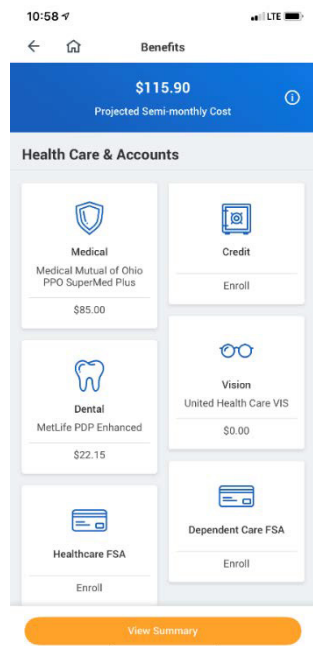


2) After downloading the app, use the Organization ID or QR code to access Workday on your smartphone or tablet.

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, 2022-November 30, 2022.**



- Make changes or updates to benefits plans directly from your phone!
- Easy access to Opt-Out options and FSA enrollments.

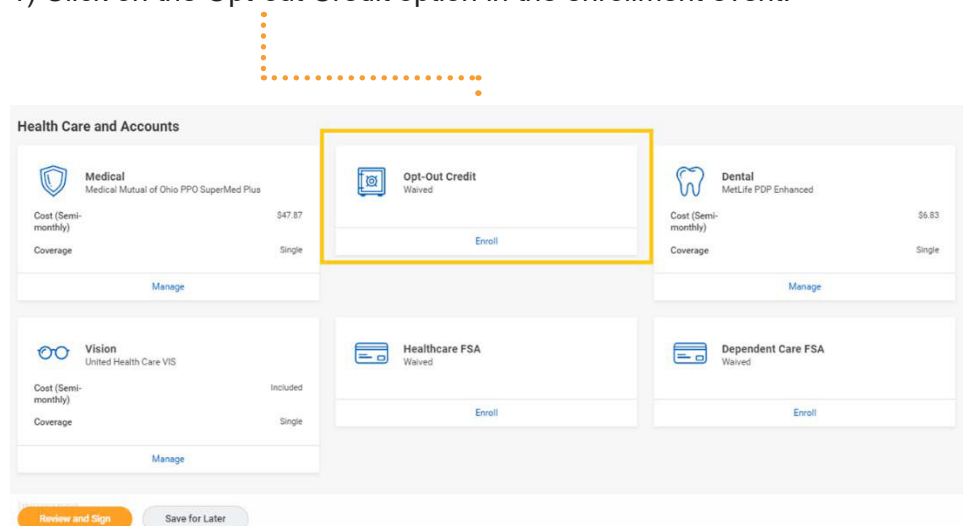
Opt-out Information

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.

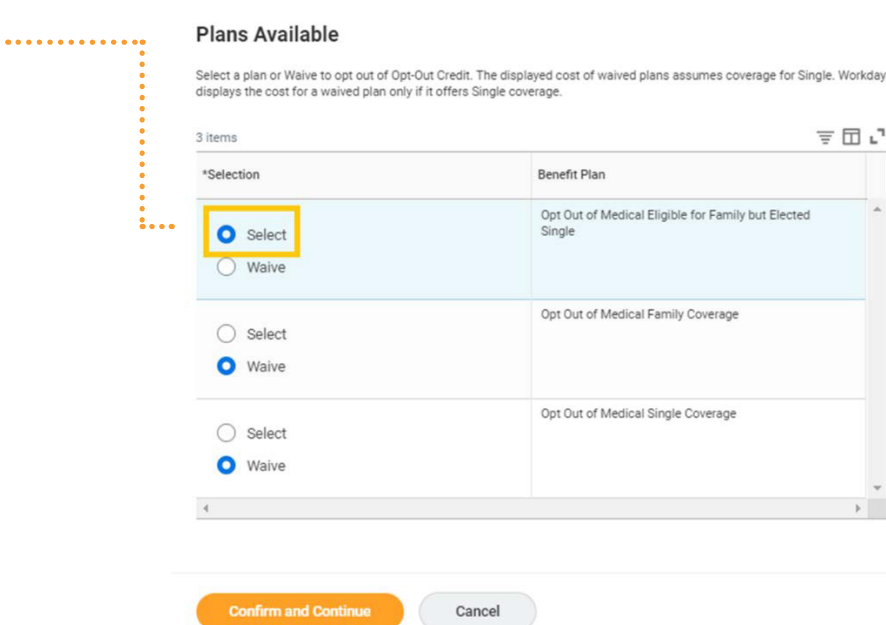
- You **MUST** submit proof of other medical coverage (coverage not provided by the Cleveland Metropolitan School District)
- Opt-Out payments will be included in the second paychecks in April and October 2022.
- If you wish to waive coverage for your eligible family members and elect single coverage for yourself, you must list your eligible dependents in the dependents section. Please see example below.

How to Opt-Out:

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



2) Click 'Select' on the plan you wish to elect and then 'Confirm and Continue'.



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.

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage * × Eligible for Family but Elected Single ... ☰

Add New Dependent

1 item

Select	Dependent	Relationship	Date of Birth
<input checked="" type="checkbox"/>	John Smith	Spouse	10/21/1987

You have dependents covered under your health care plan without a Social Security Number. Enter their Social Security Number (SSN) or Reason SSN is Not Available if you don't have access to their number at this time.

Save

Cancel



Your Opt-Out Credit changes have been updated, but not submitted

Next steps: Update another plan, or click Review and Sign once you're ready to submit your changes.



Opt-Out Credit

Opt Out of Medical Eligible for Family but Elected Single

Coverage

Eligible for Family but Elected Single

Dependents

1

Manage

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.

Submitted

You've submitted your elections.

All enrollments must be submitted by November 30, 2021. If no elections are submitted, the event will be removed from your inbox and no changes will be made.

If you are submitting these changes before November 30th and would like to make a change, please visit your Benefits App and click on the Open Enrollment task bar to update your submission.

Please note: the date of 12/15/2021 listed below is in reference to the pay period for the coverage begin date of January 1st.

****REMINDER: All changes are effective January 1, 2022.****

For any questions or issues, please email Benefits@ClevelandMetroSchools.org.

All enrollments for the 2022 calendar year are captured in the 2021 Benefits statement below. Please remember you can print a copy of your confirmation statement for your records.

Important Dates:

Benefits go into effect 12/15/2021

Final day to update benefits 11/30/2021

[View 2021 Benefits Statement](#)

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

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

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

*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 years of age, or 23 if a full-time student.

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 CONTINUATION 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
Death of a dependent	30 days
Change in your Spouse's employment status	60 days
Change in coverage status under your spouse's plan	60 days
A loss of eligibility for other health coverage	60 days

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 per year)

	Single-Wellness	Single-No Wellness	Family-Wellness	Family-No Wellness
MEDICAL				
Anthem (including prescription drug plan)	\$42.50	\$49.61	\$95.00	\$117.50
UH Choice EP Plan (including prescription drug plan)	\$17.50	\$25.00	\$50.00	\$60.00
MMO-SuperMed Plus PPO (including prescription drug plan)	\$42.50	\$55.00	\$95.00	\$117.50
Medical Plan Working Spouse Surcharge	N/A	N/A	\$75.00	\$75.00
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				
Anthem (including prescription drug plan)	\$27.63	\$35.75	\$61.75	\$76.38
UH Choice EP Plan (including prescription drug plan)	\$11.38	\$16.25	\$32.50	\$55.25
MMO-SuperMed Plus PPO (including prescription drug plan)	\$27.63	\$35.75	\$61.75	\$76.38
Medical Plan Working Spouse Surcharge	\$0	\$0	\$50	\$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

Note: CMSD correction to 1199 Spousal Surcharge rate on 11/8/2022

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:

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

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.

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

	Anthem		MMO-SuperMed Plus		UH Choice
	In-Network	Out-of Network	In-Network	Out-of Network	*Network Only
DEDUCTIBLES	2023		2023		2023
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	\$6,350	\$12,700	\$3,175	Unlimited	\$3,175
Family	\$12,700	\$25,400	\$6,350	Unlimited	\$6,350
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	\$100 copay	\$100 copay	\$100 copay	\$100 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

Prescription Drugs



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

PRESCRIPTION DRUGS 30 DAY SUPPLY AT RETAIL PHARMACY	Anthem & 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.

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.

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 2023. 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@oswaldcompanies.com

Via US Mail:

Oswald

Attn: Group Benefits - CMSD

1100 Superior Avenue, Suite 1500

Cleveland, OH 44114

HOW TO SUBMIT A WELLNESS INCENTIVE APPEAL

- Download 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.mylifeexpert.com>



<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.

mylifeexpert.com

PROGRAM DETAILS

3 Face-to-face counseling sessions per incidence and UNLIMITED 24/7 telephonic 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.

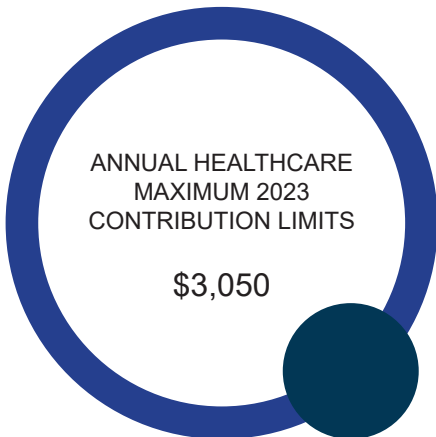
ACCESSING YOUR ACCOUNT

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 \$610 carryover each plan year. Unused contributions over \$610 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, 2023.**



Examples of Eligible Expenses



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



Dental services (excluding cosmetic services)



Dental services (excluding cosmetic services)



Dental services (excluding cosmetic services)



Dental services (excluding cosmetic services)

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.

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.

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:
 - o Name (who received service)
 - o Provider name (provider that delivered service)
 - o Date of service
 - o Type of service
 - o 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, 2023.**

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

DEDUCTIBLES	2023 Deductible		2023 Deductible	
	Individual	Family	Individual	Family
Individual	\$25.00	\$25.00	\$25.00	\$25.00
Family	\$50.00	\$50.00	\$50.00	\$50.00

MAXIMUM BENEFIT LIMITS	2023 Deductible		2023 Deductible	
	Annual Limit: Basic and Major Services	Lifetime Limit: Orthodontics	Annual Limit: Basic and Major Services	Lifetime Limit: Orthodontics
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.

Note: CMSD correction to dental deductible rates on 11/8/2022

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

- 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.

Health Savings Tips

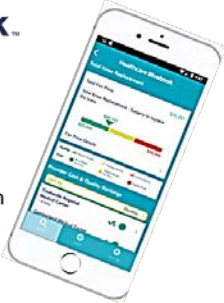





STRETCHING YOUR HEALTHCARE DOLLAR

As healthcare costs continue to rise, it is increasingly important that you take an active role in decisions about your health, the care you receive and your benefits. Here are some tips to help get you the most for your money.

**Healthcare Bluebook**
Healthcare price and quality transparency

Look up the fair value of the service(s) you need at www.healthcarebluebook.com/ prior to discussing the cost with your health care provider. If the price you are quoted is more than the listed fair value, let the provider know and ask if they can match the fair value.



-  **SEARCH** - Easily search any procedure to find out how much you should be paying in your area.
-  **COMPARE** - Bluebook's Fair Price™ information and quality rankings enable smarter healthcare decisions.
-  **SAVE** - Potentially save in out-of-pocket costs every time you receive medical care.

NOTE: Always confirm the provider and / or facility is in-network

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. Your PCP can provide necessary medical advice and identify health concerns before they become a major issue.

DON'T SKIP PREVENTIVE CARE

Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get the preventive screenings recommended for their age in order to detect health conditions early.

LIVE A HEALTHY LIFESTYLE

Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Take advantage of tobacco cessation programs. Take a walk at lunch to manage stress. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.

STAY IN-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

PRICE COMPARE PRESCRIPTIONS

Ask your provider for the generic version of a prescription. If you order your maintenance medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you, or check to ensure prescribed medications are on the plan's formulary list.

USE THE PLAN'S TOOLS & RESOURCES

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition and can possibly save you money in the long run. Look for other available resources or programs that are designed to prevent illness and lower health costs over the long run.

Prescription Opioid Awareness



BE INFORMED

We are currently experiencing a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

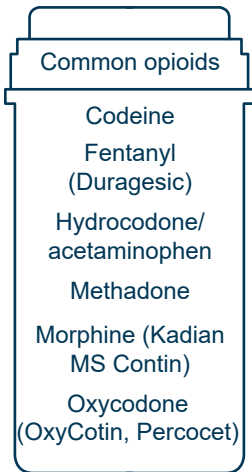
Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your healthcare provider to make sure you are getting the safest, most effective care.

WHAT'S AN OPIOID

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KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:



- Make the most informed decision.
- Work with your doctor to create a plan on how to manage your pain.
- Know your options and consider ways to manage your pain that do not include opioids.
- Talk to your doctor about any and all side effects and concerns.
- Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects. Never take opioids in greater amounts or more often than prescribed. Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor. Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family). Safely dispose of unused prescription opioids.

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- | | |
|--------------------------------------|-----------------------------|
| <i>Tolerance</i> | <i>Sleepiness/dizziness</i> |
| <i>Physical dependence</i> | <i>Confusion</i> |
| <i>Increased sensitivity to pain</i> | <i>Depression</i> |
| <i>Constipation</i> | <i>Itching and sweating</i> |

Low levels of testosterone
Nausea, vomiting and dry mouth

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

Important Terms

Brand Name Drugs A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services.

Evidence of Insurability (EOI) / Statement of Health A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Drugs Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network, and the member pays a lower amount for those services.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover. Some plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.



Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Rules such as marriage/divorce, death, termination of employment, childbirth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

Plan Notices, Disclosures & Legal Document

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

September 21, 2021

Cleveland Metropolitan School District
Benefits Help Desk
1111 Superior Ave.
Cleveland, OH 44114
216-838-0000

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within 30 days of the loss of that coverage. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:

(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

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

If you would like more information on WHCRA benefits, please call your plan administrator.

Notice Regarding Patient Protection Rights

The Cleveland Metropolitan School District group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Plan's network. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the insurer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61 percent of your household income for 2022 (9.83 percent for 2021), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Help Desk at 216-838-0000. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility:

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

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/mass-health-premium-assistance-pa Phone: 1-800-862-4840
INDIANA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	MISSOURI-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	MONTANA-Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY-Medicaid	NEBRASKA-Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	NEVADA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	NEW HAMPSHIRE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

<p align="center">NEW JERSEY-Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p align="center">UTAH-Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p align="center">NEW YORK-Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p align="center">VERMONT-Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p align="center">NORTH CAROLINA-Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">VIRGINIA-Medicaid and CHIP</p> <p>Website: https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-432-5924</p>
<p align="center">NORTH DAKOTA-Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">WASHINGTON-Medicaid</p> <p>Website: https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-432-5924</p>
<p align="center">OKLAHOMA-Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">WEST VIRGINIA-Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center">OREGON-Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p align="center">WISCONSIN-Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p align="center">PENNSYLVANIA-Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medicaid/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p align="center">WYOMING-Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>
<p align="center">RHODE ISLAND-Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItte Share Line)</p>	

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Medicare Notice

You must notify Cleveland Metropolitan School District when you or your dependents become Medicare eligible. Cleveland Metropolitan School District is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice(s) that follow.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

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

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Cleveland Metropolitan School District has determined that the prescription drug coverage offered by your company plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit U.S. Social Security Administration’s at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.

- o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at <http://www.dol.gov/ebsa> or call their toll-free number at 1-866-444-3272.

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

Wellness Program Privacy Notice

Cleveland Metropolitan School District has a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

You will also be asked to complete a biometric screening, which will include screening for Cholesterol, Glucose, blood pressure and body mass index (BMI). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will continue to contribute the same level of medical premiums as they currently pay. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive this incentive.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information.

Although the wellness program and Cleveland Metropolitan School District may use aggregate information it collects to design a program based on identified health risks in the workplace. Cleveland Metropolitan School District will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Notwithstanding these precautions, you should be aware that regardless of the safeguards in place, there is always a risk that your data could be used or disclosed other than as intended. If you are concerned about sharing your medical information through the wellness program, you can always undergo a screening directly with your physician, or you can forgo a screening entirely. It's important to balance the health benefits of regular healthcare screenings though against these privacy risks.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Cleveland Metropolitan School District, Benefits Help Desk, 1111 Superior Ave., Cleveland, OH 44114, 216-838-0000.

NOTICE OF RESCISSION OF COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

A paper copies of the SBCs are available, free of charge, by calling your benefits administrator at 216-838-0000.

Important Contacts

Chief Executive Officer

Eric S. Gordon

Board of Education

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Robert M. Heard, Sr., Vice Chair
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Dr. Michael Baston, *Ex Officio*

1111 Superior Ave | Cleveland, Ohio 44114

216-838-0000

www.clevelandmetroschools.org

The Cleveland Board of Education does not discriminate in educational programs, activities or employment on the basis of race, color, national origin, sex, sexual orientation, religion or disability.



This booklet is intended as a high level overview and is informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.