CLEVELAND METROPOLITAN SCHOOL DISTRICT

2019 ENROLLMENT

BENEFITS SUMMARY

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 24 for more details.

WHAT'S NEW IN 2019

Life Insurance: Effective January 1, 2019, MetLife will become the new Life Insurance carrier for CMSD. This change will bring lower rates for your coverage, a simplified plan design, and an opportunity to purchase additional insurance without having to answer medical questions.

The new plan will automatically combine any amounts you are currently purchasing under the Voluntary Life and Portable Life plans into a new single plan. If you are currently purchasing less than the Non-Medical Maximum Benefit (Guarantee Issue) of $100,000 you will be able to elect up to that amount without having to answer medical questions. If you are purchasing a combined total of $100,000 or more already, you will be able to purchase one additional $10,000 increment of life insurance without having to answer medical questions.

The total amount you purchase in the new combined plan will be completely portable meaning you may elect to continue your plan by paying premiums directly to the insurance carrier if you leave CMSD for any reason.

Highlights of the new combined plan include:

- Benefit Increments of $10,000 to enhanced $500,000 maximum benefit
- Increased Non-Medical Maximum Benefit Limit of $100,000 (Guaranteed Issue)
- AD&D benefit matching the amount of your elected matching the current Voluntary Portable Life AD&D benefit

Important Life Insurance Enrollment Notification*

1. Current participants will receive the sum of their Voluntary Life / Voluntary Portable Life amounts, rounded to the next higher $10,000 if not already an increment thereof
2. Participants / non-participants below $100,000 can enroll up to $100,000 (Guaranteed Issue Amount) without Evidence of Insurability (EOI)
3. Participants above $100,000 can increase one increment of $10,000 without EOI

*Your application is subject to review and approval by MetLife based upon its underwriting rules.

Vision: Replacement of the Union Eye Care vision program. Members currently covered under this program with be covered under the United Health Care plan effective January 1, 2019.

Flexible Spending Account: *Medical Mutual FlexSave will replace HealthSCOPE as the administrator of the Health Care and Dependent Care Flexible Spending Accounts effective 1/1/2019. This change will provide the opportunity to simplify claims filing and substantiation for participating members.*

Prescription Benefit Changes: Prescription benefits will once again be administered by Medical Mutual / Express Scripts. There are three important enhancements to the plan effective 1/1/2019: 90 day retail at CVS/Caremark; SaveonSP, and Accredo as the mail order partner for specialty prescriptions. Please see page 15 for further details.

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WHAT'S INSIDE

We've created a benefit package that helps you protect you and your family. We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family.

The purpose of this guide is to give you a high level overview of our benefits program. This document may also serve as a Summary of Material Modifications made to those plans. For more detailed information, refer to the summary plan documents available from Human Resources.

Thank you for your hard work.

Contact Information…………… **Page # 4**

Eligibility Overview…………… **Page # 5**

Enrollment Instructions…………… **Page # 6**

Wellness Program…………… **Page # 9**

Savings Tips…………… **Page # 10**

Cost of Coverage…………… **Page # 11**

Medical Summary Overview…………… **Page # 14**

Prescription Summary Overview…………… **Page # 15**

Hylant Script Navigator…………… **Page # 16**

Flexible Savings Account (FSA)…………… **Page # 17**

Dependent Care Account…………… **Page # 18**

Dental Benefits Overview …………… **Page # 19**

Vision Benefits Overview…………… **Page # 20**

Life and AD&D Overview…………… **Page # 21**

Employee Assistance Program Overview…………… **Page # 23**

Important Disclosures…………… **Page # 24**

Board Members…………… **Page # 35**

CONTACT INFORMATION

CMSD Employee Benefits Help Desk

1111 Superior Ave.

Cleveland, Ohio 44114

Monday – Friday 8:30 to 4:30

benefits@clevelandmetroschools.org

Medical	Medical Mutual of Ohio	1-800-228-6472	https://member.medmutual.com
Medical	Aetna	1-877-238-6201	https:/www.aetna.com
Medical	UH Choice EPO Plan	1-877-230-0992	www.myuhchoice.com
Prescription	Medical Mutual of Ohio/Express Scripts	1-800-417-1961	https://member.medmutual.com
Flexible Spending Account	Medical Mutual/ FlexSave	1-800-525-9252	https://member.medmutual.com
Dental	MetLife Dental	1-800-942-0854	www.metlife.com/mybenefits
Vision	United HealthCare	1-800-638-3120	https://www.myuhcvision.com
Life/AD&D	MetLife Life Insurance	1-800-638-6420, prompt #1 Statement of Health, prompt #2 Life claims	Life insurance calculator: www.metlife.com/mybenefits
Employee Assistance Program	Center for Families & Children Ease@Work	216-241-EASE (3273) 1-800-521-3273	www.easeatwork.com

When contacting any of the companies above, it is important to have the insurance card or ID 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.

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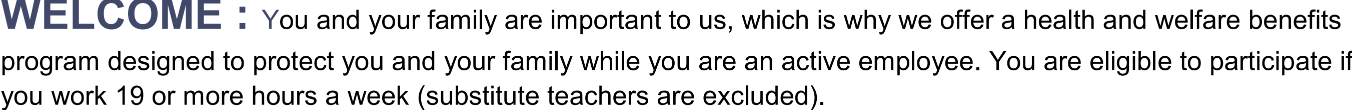
BENEFIT ELIGIBILTY OVERVIEW



WELCOME : You and your family are important to us, which is why we offer a health and welfare benefits program designed to protect you and your family while you are an active employee. You are eligible to participate if you work 19 or more hours a week (substitute teachers are excluded).

It is important that you take the time to review all of the plan options available to you. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

ELIGIBILITY: We are pleased to offer employees working 19 or more hours per week (except substitute teachers) health and welfare benefits that are designed to protect you and your family while you are employed with our organization.

Waiting Period: First of the month following a full month waiting period.

DEPENDENT ELIGIBILITY: Your dependents may also be covered under the benefit plans as described below.

****It is your responsibility to provide the Human Resources Department with proof of your dependents' eligibility. If you do not provide the required documentation your dependents will not be covered.***

Benefits	Legal Spouse	Dependent Children
Medical / Rx	☑	Up to age 26
Dental	☑	Up to age 19*
Vision	☑	Up to age 26**
Life and AD&D	☑	Up to age 21***

SPOUSAL SURCHARGE: You will incur a monthly spousal surcharge in addition to your medical coverage contributions/premiums if your spouse elects our benefits, but is working or retired and is eligible for medical coverage through their employer or former employer. The amount of the spousal surcharge is detailed on the premium rate sheets (Pages 11 & 12).

NEW HIRE COVERAGE: As a new employee, it is important for you to 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, unless you experience a qualifying event.

QUALIFYING EVENT : If you experience a family status change during the year, you may be able to make a mid-year benefit election change within 30 days of the event, in most cases. Examples of such changes include:

Qualifying Event	Timeframe to Notify HR
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 under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

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

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

**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 Vision plan has a dependent child maximum age of 26 years.

***Dependent Life Insurance has a dependent maximum child age of 21, or 23 if a full-time student.

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ENROLLING IN BENEFITS OVERVIEW

OPEN ENROLLMENT IS NOVEMBER 1, 2018 – NOVEMBER 30, 2018

The 2019 Open Enrollment is for employees enrolled in 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:***

- ***Any 2018 Flexible Spending Account (FSA) enrollment elections do not automatically renew, and must be reselected for 2019***
- ***If you previously Opted-Out of benefits, you must Opt-Out every year by selecting the opt -out option in Workday***
- ***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***
- ***Life Insurance open enrollment*:***

-Participants / non-participants below $100,000 can enroll up to $100,000 without Evidence of Insurability (EOI)

- Participants above $100,000 can increase one increment of $10,000 without EOI

-Participants/non-participants may apply for coverage above these amounts up to $500,000 in increments of $10,000 by completing a statement of health

****Your application is subject to review and approval by MetLife based upon its underwriting rules***

YOU MUST USE THE INTERNET TO ENROLL OR MAKE BENEFIT CHANGES

You can access the 2019 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. Notification and instructions for Open Enrollment can be found through the Workday inbox.

AMOUNT OF THE SPOUSAL SURCHARGE IS IDENTIFIED ON THE PREMIUM RATE PAGES.

If an employee enrolls his/her spouse in the District's health insurance program and that spouse is eligible to participate (either as a current employee or retiree) in group health insurance sponsored by his/her employer or retirement plan, the bargaining unit member shall pay an additional monthly premium contribution for family coverage. However, the additional employee contribution will not apply upon the spouse's enrollment in his/her employer's healthcare plan or retirement plan, that plan will provide primary coverage for the spouse and the District's plan will provide secondary coverage so long as the employee is enrolled in the District's family coverage.

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ENROLLING IN BENEFITS

HOW TO ENROLL OR MAKE A CHANGE

STEP 1: Use Workday on an Internet enabled device or computer 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, 2018 through November 30, 2018.

STEP 2: After you have enrolled, a **Confirmation Statement** will be displayed to verify your benefit elections**. Please print a copy to keep as a receipt for your records**.

To make changes for a qualifying life event, log in to Workday and complete the following steps:

1) Click on you Benefits Worklet.

2) Under "Change", choose Benefits.

3) Select your Benefit Event Type.

4) Enter Benefit Event Date.
(Ex) date of birth of a newborn, date of marriage, etc.

5) Be sure to attach a document or the event WILL NOT be processed.
Ex) proof of birth letter, marriage certificate, etc.
Simply click on the "+" under Attachments to upload the document.

6) Click "Submit" at the bottom of the screen and you will prompted* to *make your enrollment selections.

7) Once the event is completed and submitted, it will be sent to Benefits or approval. If anything is missing, the event will be sent back to you with the option to make the necessary corrections.

If you need help, or have questions email:

benefits@clevelandmetroschools.org

Open Enrollment sessions will be scheduled during open enrollment again this year at East Professional Center. Typically these sessions are scheduled on either Mondays or Fridays and further information will be provided during our open enrollment process.

Life insurance beneficiaries must be designated in the Workday enrollment system.

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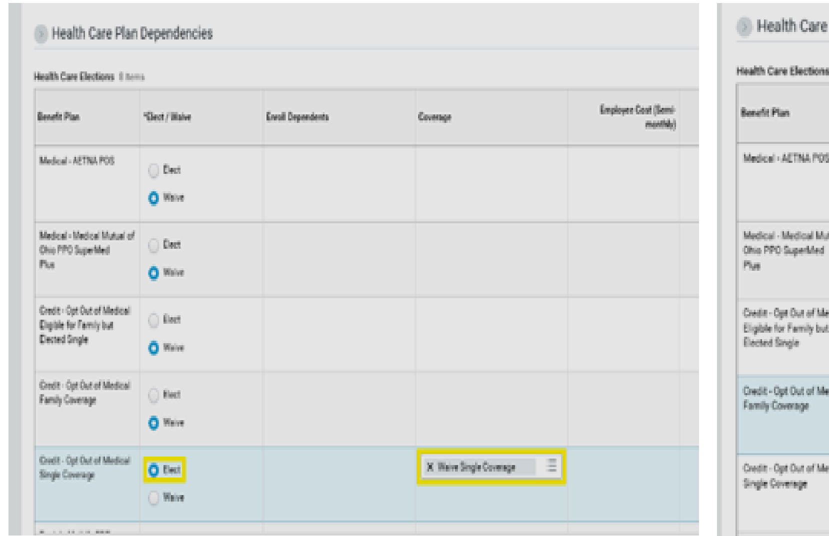
OPT-OUT RULES

STEP 1: 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. Please see examples below.

a) Opt-out of Single Coverage

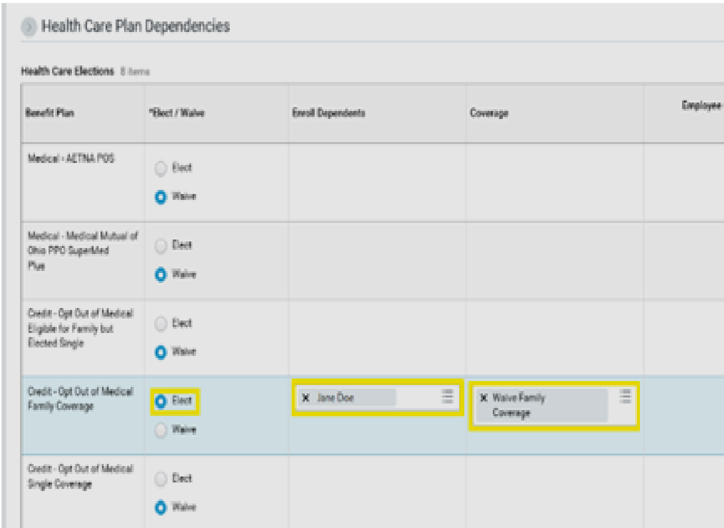
b) Opt-out of Family Coverage



Health Care Plan Dependencies

Health Care Elections 8 items

Benefit Plan	*Elect / Waive	Enroll Dependents	Coverage	Employee Cost (Semi-monthly)
Medical - AETNA POS	Waive			
Medical - Medical Mutual of Ohio PPO SuperMed Plus	Waive			
Credit - Opt Out of Medical Eligible for Family but Elected Single	Waive			
Credit - Opt Out of Medical Family Coverage	Waive			
Credit - Opt Out of Medical Single Coverage	Elect		Waive Single Coverage	



Health Care Plan Dependencies

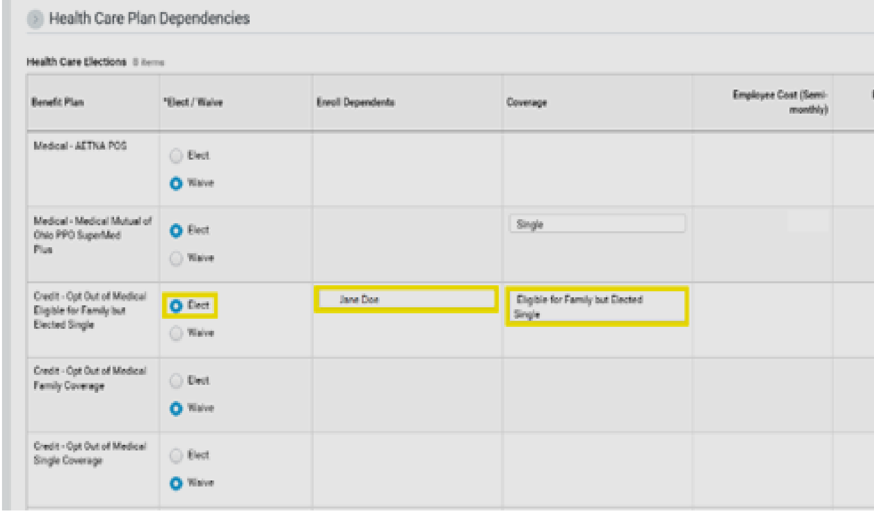
Health Care Elections 8 items

Benefit Plan	*Elect / Waive	Enroll Dependents	Coverage	Employee C
Medical - AETNA POS	Waive			
Medical - Medical Mutual of Ohio PPO SuperMed Plus	Waive			
Credit - Opt Out of Medical Eligible for Family but Elected Single	Waive			
Credit - Opt Out of Medical Family Coverage	Elect	Jane Doe	Waive Family Coverage	
Credit - Opt Out of Medical Single Coverage	Waive			

STEP 2: You **MUST** submit proof of other medical coverage (coverage not provided by the Cleveland Metropolitan School Dis-

STEP 3: Opt-Out payments will be included in the second paychecks in April and October 2019.

STEP 4: 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



Health Care Plan Dependencies

Health Care Elections 8 items

Benefit Plan	*Elect / Waive	Enroll Dependents	Coverage	Employee Cost (Semi-monthly)
Medical - AETNA POS	Waive			
Medical - Medical Mutual of Ohio PPO SuperMed Plus	Elect		Single	
Credit - Opt Out of Medical Eligible for Family but Elected Single	Elect	Jane Doe	Eligible for Family but Elected Single	
Credit - Opt Out of Medical Family Coverage	Waive			
Credit - Opt Out of Medical Single Coverage	Waive			

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.

Note: Please review your confirmation page upon submitting your elections. If the Opt-Out Credit option is not elected, the Health Care Waiver WILL NOT be paid.

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WELLNESS PROGRAM OVERVIEW

Your health and well-being are very important to us and to you. We want to provide you with tools and resources to help you live your best. With participation in the CMSD wellness program you may continue your current premiums without increase for 2019. For most participants the deadline for submission of completed forms is October 31,2018. New participants in the plan must submit forms no later than 60 days following initial plan eligibility.

Who Is Eligible for the Wellness Program

The Cleveland Metropolitan School District has established a wellness incentive for eligible participants who complete the following activities:

To qualify the member must have submitted physician certification of having completed the listed activities. ***Please note: The actual results, diagnoses and/or any other details of any testing or assessment are not to be included.***

1. The Physician Certification Form Includes:

- Cholesterol screening
- Glucose screening
- Blood Pressure screening

2. CMSD Risk Assessment form

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

WAYS TO IMPROVE YOUR HEALTH AND LOWER YOUR COSTS:

To be eligible to continue at the current premium level, you must:

1. Take the Physician Certification Form to your doctor, nurse practitioner or physician's assistant

2. Provide the completed CMSD Health Risk Assessment to your physician.

3. Physician or employee may submit the form via email, or US Mail to:

***Via Email**:*

CMSDHRA@Hylant.com

Via US Mail:

Hylant

Attn: CMSD HRA

6000 Freedom Square Dr., Suite 400

Cleveland, OH 44131

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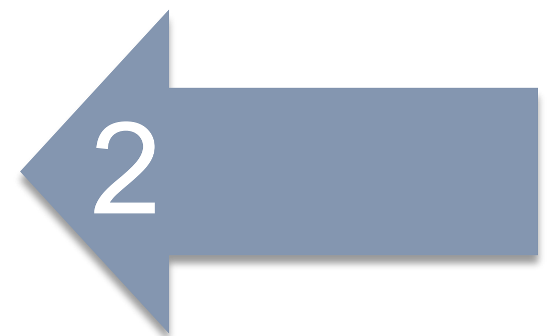
COST SAVINGS TIPS AND HEALTH TIPS

KEEP YOURSELF AND YOUR FAMILY HEALTHY

Exercising, eating right, managing stress and not smoking are just some of the ways to prevent health problems from developing. Take advantage of preventive health services covered by your insurance plan. It is less costly to prevent illness than to treat a disease.



GO TO IN-NETWORK VERSUS OUT-OF-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.

3

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. A visit to your primary care physician is usually less expensive compared to an urgent care or emergency room visit.

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COST OF COVERAGE OVERVIEW

Contribution rates for the remainder of the 2018/2019 school year (See Page 13 Table 1)

Full Time Employees[1] assigned to work a minimum of 19 hours per week ***(Except members of District 1199 earning $27,000 or less per year)***	**Single — Wellness**	**Single — No Wellness**	**Family — Wellness**	**Family— No Wellness**
Aetna (includes prescription drug plan)	$37.50	$39.43	$85.00	$96.80
UH Choice EPO Plan (includes prescription drug plan)	$17.50	$25.00	$50.00	$60.00
MMO-SuperMed Plus PPO (includes prescription drug plan)	$37.50	$40.68	$85.00	$97.05
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
Vision (United HealthCare)	$0	$0	$0	$0
Working Spouse For All Medical Plans	N/A	N/A	$50.00	$50.00

Based upon 24 deductions taken from the first two paychecks of each month.

Full Time District 1199 Employees[1] assigned to work a minimum of 19 hours per week earning $27,000 or less per year	**Single — Wellness**	**Single — No Wellness**	**Family — Wellness**	**Family— No Wellness**
Aetna (includes prescription drug plan)	$24.38	$32.50	$55.25	$71.50
UH Choice EPO Plan (includes prescription drug plan)	$11.38	$16.25	$32.50	$55.25
MMO-SuperMed Plus PPO (includes prescription drug plan)	$24.38	$32.50	$55.25	$71.50
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
Vision (United HealthCare)	$0	$0	$0	$0
Working Spouse For All Medical Plans	N/A	N/A	$37.50	$37.50

Based upon 24 deductions taken from the first two paychecks of each month.

[1]Qualifying eligibility hours are based on District approved assignments and hours. Review your collective bargaining agreement for specific coverage and eligibility rules.

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COST OF COVERAGE OVERVIEW

Contribution rates for the remainder of the 2019 calendar year **(See Page 13 Table 2)**

Full Time Employees[1] 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**
Aetna (includes prescription drug plan)	$37.50	$42.72	$85.00	$105.33
UH Choice EPO Plan (includes prescription drug plan)	$17.50	$25.00	$50.00	$60.00
MMO-SuperMed Plus PPO (includes prescription drug plan)	$37.50	$43.69	$85.00	$104.25
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
Vision (United HealthCare)	$0	$0	$0	$0
Working Spouse For All Medical Plans	N/A	N/A	$50.00	$50.00

Based upon 24 deductions taken from the first two paychecks of each month.

Full Time District 1199 Employees[1] 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**
Aetna (includes prescription drug plan)	$24.38	$32.50	$55.25	$71.50
UH Choice EPO Plan (includes prescription drug plan)	$11.38	$16.25	$32.50	$55.25
MMO-SuperMed Plus PPO (includes prescription drug plan)	$24.38	$32.50	$55.25	$71.50
Basic Dental (MetLife)	$0	$0	$0	$0
Enhanced Dental (MetLife)	$6.83	$6.83	$22.15	$22.15
Vision (United HealthCare)	$0	$0	$0	$0
Working Spouse For All Medical Plans	N/A	N/A	$37.50	$37.50

Based upon 24 deductions taken from the first two paychecks of each month.

[1]Qualifying eligibility hours are based on District approved assignments and hours. Review your collective bargaining agreement for specific coverage and eligibility rules.

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COST OF COVERAGE OVERVIEW

Table 1: Final payroll date for page 11 contributions

CLASSIFICATION(S)	Last Check
Assistant Principals, CIS Curriculum Specialist Campus Coordinators	7/12/2019
Dean of Culture, Life Skills Coach, Dean of Engagement, Guidance Counselors	7/12/2019
Teachers, Paraprofessionals, and Substitutes @ Year Round/Extended Schools	7/19/2019
Secretaries @ Year Round / Extended Schools	7/12/2019
Security Officers @ Year Round / Extended Schools	7/12/2019
Teachers, Paraprofessionals, and Substitutes @ Traditional 185-Day Schools	8/5/2019
Secretaries @ Traditional 185-Day Schools	7/26/2019
Security Officers @ Traditional 185-Day Schools	7/26/2019
Food Service Specialists	8/9/2019
Environmental Service Specialists	7/12/2019
Transportation 10 Month Drivers	8/9/2019
All other employees working 260 days per year	7/12/2019

Table 2: First payroll date for page 12 contributions

CLASSIFICATION(S)	First Check
Assistant Principals, CIS Curriculum Specialist Campus Coordinators	7/26/2019
Dean of Culture, Life Skills Coach, Dean of Engagement, Guidance Counselors	7/26/2019
Teachers, Paraprofessionals, and Substitutes @ Year Round/Extended Schools	8/5/2019
Secretaries @ Year Round / Extended Schools	7/26/2019
Security Officers @ Year Round / Extended Schools	7/26/2019
Teachers, Paraprofessionals, and Substitutes @ Traditional 185-Day Schools	8/20/2019
Secretaries @ Traditional 185-Day Schools	8/9/2019
Security Officers @ Traditional 185-Day Schools	8/9/2019
Food Service	8/23/2019
Environmental Service Specialists	7/26/2019
Transportation 10 Month Drivers	8/23/2019
All other employees working 260 days per year	7/26/2019

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MEDICAL BENEFITS OVERVIEW

MEDICAL COVERAGE

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage or SBC. You may access a list of

Administrator: See page 3

	Aetna		MMO-Supermed Plus		UHChoice
	In-Network	Out-of-Network	In-Network	Out-of-Network	*Network Only
DEDUCTIBLES	2019		2019		2019
Individual	$0	$250	$0	$250	$0
Family	$0	$500	$0	$500	$0
COINSURANCE					
Plan Pays	100%	70%	100%	80%	100%
You Pay	$0	30%	0%	20%	0%
OUT OF POCKET MAXIMUM					
Individual	$0	$2,250	$0	$2,000	$0
Family	$0	$4,500	$0	$4,000	$0
COMMONLY USED SERVICES					
Physician Visit	$20 copay	70% after deductible	$20 copay	80% after deductible	$10 copay
Specialty Visits	$30 copay	70% after deductible	$30 copay	80% after deductible	$25 copay
Preventive Care Services	100% coverage	70% after deductible	100% coverage	80% after deductible	100% coverage
Urgent Care Visit	$35 copay	70% after deductible	$35 copay	80% after deductible	$25 copay
Emergency Room	$75 copay	$75 copay	$75 copay	$75 copay	$50 copay
Diagnostic Labs & X-Rays	100%	70% after deductible	100%	80% after deductible	100%
Hospitalization	100%	70% after deductible	100%	80% after deductible	100%
Mental Health	100%	70% after deductible	100%	80% after deductible	100%
Substance Abuse	100%	70% after deductible	100%	80% after deductible	100%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

**Out of Network benefits available for emergencies while traveling out of the Network. Students may also access benefits while attending school out of the Network area.*

See Summary Plan Document for additional details. You may also contact the plan administrator with questions regarding benefits.

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PRESCRIPTION DRUGS

PRESCRIPTION DRUGS** - 30 Day Supply at Retail Pharmacy	Aetna & MMOH	UH Choice
Generic	$5 copay	$5 copay
Formulary	$15 copay	$10 copay
Non-Formulary	$20 copay	$10 copay
Contraceptives	Covered	

PRESCRIPTION DRUGS** - 90 Day Supply at Mail Order or 90 Day Supply at CVS/ Caremark	Aetna & MMOH	UH Choice
Generic	$10 copay	$5 copay
Formulary	$30 copay	$10 copay
Non-Formulary	$40 copay	$10 copay

Express Scripts

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 script 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 may fill all routine maintenance medications through mail order . Members may also fill a 90 day script at retail at CVS/Caremark.

Specialty Mail Order: Accredo will help members to manage their specialty pharmacy 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.

SaveonSP: Saves plan members money by maximizing prescription drug copay assistance from pharmaceutical manufactures with coupons. With Saveon SP, plan savings on specialty drugs average nearly 13 percent while members' out-of-pocket responsibility is reduced to $0.

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HYLANT SCRIPT NAVIGATOR

- Identify discounted generic drug programs available at pharmacies throughout the USA
- Visit ***hylantscriptnavigator.com***
  - Enter in the name of the drug
  - Dosage amount
  - Your zip code

Feel free to share this resource with family and friends!

Pharmacies nationwide sell select generic drugs at a discounted rate. You can find the best deals on your medications by identifying the pharmacies that offer these programs. Generic drugs are distributed as the equivalent to the brand name however you should talk to your doctor if you have specific questions about your prescription.

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FLEXIBLE SPENDING ACCOUNTS (FSA)

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account 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 copayments, deductibles, eyeglasses, contact lenses, prescriptions and other health-related expenses that are not reimbursed by insurance.

HOW DOES IT WORK?

You decide how much to contribute to your Healthcare FSA on a plan year basis to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck 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 except Building Trades have a $500 carryover each plan year.

Building Trades participants have an extension through 3/15 of the following year to incur additional claims against any remaining balance from the previous year.

Annual Healthcare FSA Maximum 2019 Contribution Limits	
Healthcare FSA	**$2,650**

SAMPLE ELIGIBLE EXPENSES

- **Unreimbursed medical expenses (deductibles, coinsurance, copay, etc.)**
- **Dental services (excluding cosmetic services)**
- **Orthodontia**
- **Glasses, contacts, and eye exams**
- **Lasik eye surgery**

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO AN FSA

- You cannot take income tax deductions for expenses you pay with your Healthcare &/or Dependent Care 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 2019**

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DEPENDENT CARE FSA OVERVIEW

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

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

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

CLAIMS REIMBURSEMENT:

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

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

Annual Dependent Care FSA Maximum 2019 Contribution Limits	
Single	**$2,500**
Married Filing Jointly	**$5,000**

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as the funds are "use it or lose it". Any unused funds at the end of the year will automatically be forfeited.
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (*unless you experience certain life events, called Permitted Election Change Events that allow a special mid-year enrollment.)*
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:

- Name (who received service)
- Provider name (provider that delivered service)
- Date of Service
- Type of service
- Cost of service

SAMPLE ELIGIBLE EXPENSES

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature

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

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

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DENTAL BENEFITS OVERVIEW

Administrator: MetLife

DENTAL COVERAGE

You have access to an extensive network of dentists. You may access a list of participating providers through the MetLife Website.

	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 age 14); Bitewing X rays (1per 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 & consultations	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 Under age 19	20% of *PDP	20% of **R&C	80% of *PDP	80% of **R&C

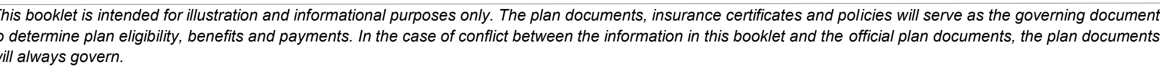
Deductible	Plan Year Deductible		Plan Year Deductible	
Individual	$25	$25	$25	$25
Family	$50	$50	$50	$50
Maximum Benefit Limits				
Annual Limit Basic & Major Services	$1,500	$1,500	$2,500	$2,500
Lifetime Limit: Orthodontics	$1,500	$1,500	$2,500	$2,500

*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.

Benefits of choosing In-Network providers:

- No balance billing for amounts overcharges
- Discounted pricing
- Doctors have been thoroughly screened



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VISION BENEFITS OVERVIEW

VISION COVERAGE

You have access to an extensive network of private practicing optometrists, ophthalmologists, opticians and optical retailers. You may access a list of participating providers through the UHC Vision website.

Administrator: United HealthCare

www.myuhcvision 800-638-3120

	Full-time employees working 19 or more hours per week enrolled in vision coverage
	In-Network
Exam: ▪One exam every 24 months for employees and dependents 19 years of age or older. ▪Once every 12 months for employees and dependents under age 19.	$0 copay
▪**Lens / Frames** One pair every 24 months for employees and dependents 19 years of age or older ▪ One pair every 12 months for employees and dependents under age 19	Single Vision $45 copay Standard Bifocals Standard Trifocals Lenticular or Aphakic Lens Frames on display
Contact Lenses ▪One pair every 24 months for employees and dependents 19 years of age or older ▪Once every 12 months for employees and dependents under age 19 ▪In lieu of spectacle lenses and a frame ▪Cosmetic and Medically Necessary contact lenses are covered in full (up to 4 boxes of disposable lenses)	Contact lenses $45.00 copay

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.

Dependent child coverage is provided to eligible children until age 26

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LIFE INSURANCE

BASIC LIFE INSURANCE IS PAID IN FULL BY CLEVELAND METROPOLITAN SCHOOL DISTRICT

Administrator: MetLife

Life Insurance

www.metlife.com/mybenefits

800-942-638-6420

VOLUNTARY PORTABLE LIFE INSURANCE*:

You have the opportunity to elect Voluntary Life Insurance. 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.

Your application is subject to review and approval by MetLife based upon its underwriting rules

	Voluntary Life Coverage	
		Employee
Employee Contributions for Life Insurance	Age Schedule	Monthly Rate per $10,000 of coverage
	Under age 25	$0.26
	25-29	$0.26
	30-34	$0.26
	35-39	$0.35
	40-44	$0.53
	45-49	$0.88
	50-54	$1.23
	55-59	$2.11
	60-64	$3.60
	65-69	$5.62
	70 and over	$8.78

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

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HOW VOLUNTARY LIFE INSURANCE IS CHANGING

Old Voluntary & Portable Life Insurance Plans (12/31/2018 and earlier)		**New Voluntary Portable Life Plan**
Voluntary Life Insurance	Portable Life Insurance	
Plan Overview $25,000 Units Maximum $150,000 Guaranteed: $25,000 Not Portable Example: 45 years old electing $50,000 Monthly Premium: $5.50	Plan Overview $10,000 Units Maximum: $300,000 Guaranteed: $0 Portable Example: 45 years old electing $10,000 Monthly Premium: $0.80	Plan Overview $10,000 Units Maximum: $500,000 Guaranteed: $100,000 Portable Example: $60,000 with option at November 2018 Open Enrollment to buy up to $100,000 Guarantee without Evidence of Insurability.
Combined Total **$60,000 total benefit with $10,000 portable if no longer employed at CMSD** **Monthly Premium: $6.30**		**$60,000 fully portable** **Monthly Premium: $5.28**

How to calculate New Voluntary Portable Life Plan Rates:

1. Total amount of life insurance desired. $_________________
(Up to $100,000 Guaranteed or next multiple of $10,000, if total combined under Old Voluntary & Portable Life Insurance Plans exceeds $100,000.) / 10,0000

2. Divide Line 1 by $10,000. $_________________

3. Enter rate per $10,000 based on your age from the table on Page 19. $_________________
X

4. Multiply Amount in Line 2 by the Rate in Line 3. $_________________

This is the total monthly premium based upon your age and Insurance amount.

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EMPLOYEE ASSISTANCE PROGRAM

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.

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

216-241-EASE (3273) or 1-800-521-3273 or http://www.easeatwork.com

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

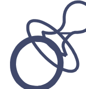
You have three face-to-face sessions with a behavioral counselor available to you and your house-hold members. Call us to request a referral.

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.

ASSISTANCE IS AVAILABLE FOR THE FOLLOWING PERSONAL AND WORK LIFE SITUATIONS:

- Marital and family problems
- Parenting
- Teen Resources (dating, bullying, eating concerns, etc.)
- Work-related difficulties
- Emotional problems
- Relationship difficulties
- Alcohol and substance abuse
- Domestic violence
- Health and wellness resources
- Personal financial management
- Legal and financial resources and counseling



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IMPORTANT DISCLOSURES

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:

Cleveland Metropolitan School District
Human Resources
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

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- 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 MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

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 health care professional in the Plan's network. The health care 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 health care professionals, please contact the insurer.

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 on the next page.

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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 eligible for Medicare.

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)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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

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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 (penalty).

Cleveland Metropolitan School District
Human Resources
1111 Superior Ave
Cleveland, OH 44114
(216) 838-0000

NEW 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?

Today, there is a new 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

IMPORTANT DISCLOSURES

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 9.69 percent of your household income for 2017 (9.56 percent for 2018), 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:

Cleveland Metropolitan School District
Human Resources
1111 Superior Ave
Cleveland, OH 44114
(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 **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.

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IMPORTANT DISCLOSURES

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.

IMPORTANT DISCLOSURES

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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

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KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	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 12/31/2019)

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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.

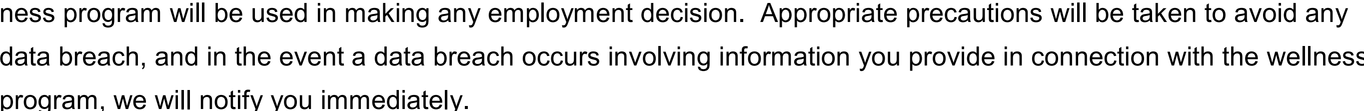
Protections from Disclosure of Medical Information

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, [name of wellness program] 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 well-



ness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Cleveland Metropolitan School District
Human Resources
1111 Superior Ave
Cleveland, OH 44114
(216) 838-0000

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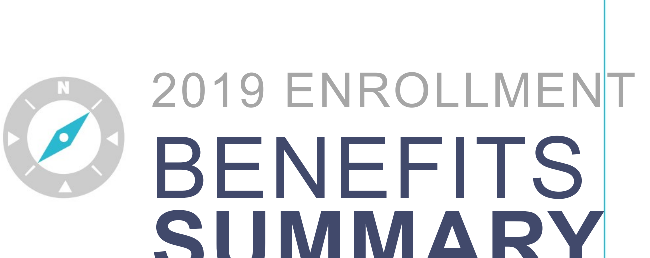
2019 ENROLLMENT
BENEFITS
SUMMARY

CLEVELAND
METROPOLITAN
SCHOOL DISTRICT