2019 benefit options
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The district pays the entire premium of medical, dental and life insurance for employees who work 35 hours or more per week. Part-time employees working 30-34 hours per week are eligible to purchase medical, dental, and life insurance.

Non-exempt (hourly) employees: first day of the month following 60 days of employment.
Exempt (salaried) employees: date of hire.

Children are covered to the age of 26 on the medical, dental & vision plans.
Dependent enrollment for medical, dental & vision is available and the premium is paid 100% by the employee via payroll deductions.
Elections may be changed during the plan year as a result of a Qualifying Event: birth, marriage, or loss of coverage through spouse’s/Domestic Partner’s employer, etc.

*Failure to submit your elections within 31 days of hire will result in auto-enrollment in the Plus Plan, Dental Plan, and Basic Life Plan. All other Benefits options will be waived.
qualifying life events

The choices you make during your New Hire period or Annual Open Enrollment period are irrevocable until either the next Annual Open Enrollment period or unless you experience a qualifying life event.

Qualifying life events include changes to your legal marital status, giving birth or adopting a child, a change in you or your spouse’s/domestic partner’s employment status or your entitlement to Medicare.

If you anticipate any of these changes, please contact Employee Benefits in advance of the event to verify your right to change plan coverage(s). You must submit the online change form to elect your change in benefits within 31 days of the qualifying life event. NOTE: ALL PREMIUMS ARE PAID IN ADVANCE. Employees must request to stop coverage in writing via the online change form in the month(s) prior to the date of the qualifying event in order to stop the premium deduction.

If you do not submit the online change form to notify Employee Benefits within 31 days of a qualifying event, you will have to wait until the next Annual Open Enrollment period to make benefit changes unless you have another qualifying event.
**how to enroll**

If you will be electing coverage this year, you will need to follow these directions to complete the process. If you have trouble enrolling, contact a member of our Employee Benefits Office.

**Step One**
Login into your CPS Portal and click on the BenefitFocus icon.

**Step Two**
Click on the Enroll Now! icon.

**Step Three**
Click on the Get Started icon.

**Step Four**
The first item you’ll be directed to complete is to add dependents. If you have no intent to add dependents to any of the benefits offered through CPS, you may click Next. If you want to see the monthly premium cost of adding dependent/s to medical, dental and/or vision, and/or pick and choose which benefits you want the dependent/s to have coverage, then click Add Dependent.

**PLEASE NOTE:** adding dependents at this step does not result in receiving benefit coverage. Add dependents to specific coverages within the following steps.
enrollment & eligibility

how to enroll

Step Five
Your first benefit to enroll in will be Medical coverage. The enrollment platform will then walk you through all available coverages and associated steps.

Step Six
Click Save often as you progress through the enrollment platform. In the event you have to stop in the midst of enrollment, you can return to where you stopped but you must click Save before exiting the enrollment platform.

Step Seven
After you have completed all steps of your enrollment, you will see a summary page. You may print this summary page. You may return to the enrollment platform to alter your elections, but you must do so within the allowed 31-day window.

PLEASE NOTE: The enrollment platform is not available upon the 31-day window closing.

Questions & Technical Assistance
Questions about your Benefits offered through CPS?
• Call CPS Employee Benefits, Mon-Fri, 7:30am-4:30pm, at 573-214-3710

Need Technical Assistance with the BenefitFocus enrollment platform?
• Call BenefitFocus, Mon-Fri 7am-8pm, at 877-336-8082 -or- Live Chat with a representative
## Contact Information

Please refer to this list when you need to contact one of your benefit vendors. For general information contact Employee Benefits.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Whom To Call</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>CoreSource Group: CP0000</td>
<td>(800) 990-9058</td>
<td><a href="http://www.mycoresource.com">www.mycoresource.com</a></td>
</tr>
<tr>
<td>Medical Network</td>
<td>HealthLink Open Access III Network</td>
<td>(800) 624-2356</td>
<td><a href="http://www.healthlink.com">www.healthlink.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Ameritas Group: 301036</td>
<td>(800) 487-5553</td>
<td><a href="http://www.amertias.com">www.amertias.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>NVA Group: 8846000001</td>
<td>(800) 672-7723</td>
<td><a href="http://www.e-nva.com">www.e-nva.com</a></td>
</tr>
<tr>
<td>Short/Long Term Disability</td>
<td>The Hartford</td>
<td>(800) 303-9744</td>
<td><a href="http://www.thehartford.com">www.thehartford.com</a></td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Kansas City Life Group Life: GL3929 Supplemental Life: SL3929</td>
<td>(800) 874-5254</td>
<td></td>
</tr>
<tr>
<td>Flexible Spending Account (FSA)</td>
<td>ASI</td>
<td>(800) 659-3035</td>
<td><a href="http://www.asiflex.com">www.asiflex.com</a></td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>Landmark Bank</td>
<td>Walk-in or call any branch</td>
<td><a href="http://www.landmarkbank.com">www.landmarkbank.com</a></td>
</tr>
<tr>
<td>EAP</td>
<td>Boone Hospital</td>
<td>(573) 815-6034 (877) 327-0327</td>
<td><a href="http://www.boone.org/eap">www.boone.org/eap</a></td>
</tr>
<tr>
<td>State Retirement</td>
<td>PSRS/PEERS</td>
<td>(800) 392-6848</td>
<td><a href="http://www.psrs-peers.org">www.psrs-peers.org</a></td>
</tr>
<tr>
<td>Voluntary Retirement</td>
<td>TIAA 403(b) &amp; 457(b)</td>
<td>(800) 842-2638</td>
<td><a href="http://www.tiaa.org/cpsk12">www.tiaa.org/cpsk12</a></td>
</tr>
</tbody>
</table>
medical plans

Employee well-being is a top priority at Columbia Public Schools. Through CoreSource and HealthLink, we’re proud to offer you access to an extensive network of providers. You and your family will be able to maintain your well-being with preventive care and affordable prescription medication.

There are two medical plans to choose from:

1. Plus Plan – A qualified High Deductible Plan that offers you the opportunity to open a Health Savings Account (HSA), if you are eligible. An HSA allows you, and Columbia Public Schools, to contribute tax-free dollars to use toward out-of-pocket health expenses. See page 15 for additional information regarding an HSA and the employer contribution.

2. Basic Plan – A traditional PPO plan

Choosing the right medical plan is an important decision for you and your family. Take the time to review your family’s past medical expenses and what expenses you are likely to incur during the upcoming plan year. Use this information to determine what kind of coverage is best for you and your family.
Medical

per pay period deductions

<table>
<thead>
<tr>
<th></th>
<th>Plus Plan</th>
<th>Basic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-Time EE Only (35+ hrs)</strong></td>
<td>$607 (District Paid)</td>
<td>$663 (District Paid)</td>
</tr>
<tr>
<td><strong>Part-Time EE Only (30-34 hrs)</strong></td>
<td>$85</td>
<td>$93</td>
</tr>
<tr>
<td><strong>Spouse/Domestic Partner</strong></td>
<td>$607</td>
<td>$663</td>
</tr>
<tr>
<td><strong>One Child</strong></td>
<td>$274</td>
<td>$299</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>$474</td>
<td>$518</td>
</tr>
<tr>
<td><strong>Spouse/Domestic Partner + One Child</strong></td>
<td>$881</td>
<td>$962</td>
</tr>
<tr>
<td><strong>Spouse/Domestic Partner + Children</strong></td>
<td>$1,081</td>
<td>$1,181</td>
</tr>
</tbody>
</table>
staying in-network

If you choose to see an out-of-network provider or pharmacy, you will still be able to use insurance, however, your costs will be substantially higher and your deductible and out-of-pocket maximums will be higher.

Your medical network is made up of:

- convenience care (quick) clinics
- physicians
- facilities (urgent care, emergency room)
- nurse practitioners
- specialists
- pharmacies

When you see an in-network provider, you will:

- Have lower health care costs for medical services and prescription drugs.
- No need to obtain pre-authorization before a procedure such as surgery, your in-network provider will handle this on your behalf.
- Not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary.
- Not have to fill out forms to send to the insurance carrier in order to receive reimbursement, your in-network provider will handle this on your behalf.

How to find an in-network provider

- Visit HealthLink at www.healthlink.com, click Find a Doctor, and select Columbia Public Schools from the Health Plan drop-down on the left.
- Call (800) 624-2356
- You have access to the Open Access III Network and Freedom Network Select

Tip

When possible, choose urgent care facilities over the emergency room to save time and money.
### Benefit Summary

<table>
<thead>
<tr>
<th></th>
<th>Plus Plan</th>
<th>Basic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$2,000/$4,000* Single/Family</td>
<td>$750/$1,500 Individual/Family</td>
</tr>
<tr>
<td>(Amount paid by member)</td>
<td>$2,000/$4,000* Single/Family</td>
<td>$900/$1,800 Individual/Family</td>
</tr>
<tr>
<td></td>
<td>100% covered before deductible</td>
<td>100% covered before deductible</td>
</tr>
<tr>
<td></td>
<td>per ACA</td>
<td>per ACA</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>100% covered before deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>per ACA</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Initial/Medical</strong></td>
<td>$2,000/$4,000 Single/Family</td>
<td>$2,250/$4,500 Individual/Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Max</strong></td>
<td>$6,000/$12,000 Single/Family</td>
<td>$3,150/$6,300 Individual/Family</td>
</tr>
<tr>
<td></td>
<td>Medical + 100% cost of Rx apply</td>
<td>When Medical out-of-pocket maximum</td>
</tr>
<tr>
<td></td>
<td>towards initial out-of-pocket</td>
<td>is met, insurance pays 100% of</td>
</tr>
<tr>
<td></td>
<td>maximum</td>
<td>eligible medical expenses</td>
</tr>
<tr>
<td><strong>Rx Copay</strong></td>
<td>$2,000/$2,000 Single/Family</td>
<td>$1,500/$3,000 Individual/Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Max</strong></td>
<td>$2,000/$4,000 Single/Family</td>
<td>$2,100/$4,200 Individual/Family</td>
</tr>
<tr>
<td></td>
<td>Rx copays begin after initial</td>
<td>When Rx out-of-pocket maximum is</td>
</tr>
<tr>
<td></td>
<td>out-of-pocket maximum is met,</td>
<td>met, eligible Rx is covered 100%</td>
</tr>
<tr>
<td></td>
<td>eligible Rx is covered 100%</td>
<td></td>
</tr>
<tr>
<td><strong>Combined Annual</strong></td>
<td>$4,000/$6,000 Single/Family</td>
<td>$3,750/$7,500 Individual/Family</td>
</tr>
<tr>
<td><strong>total of</strong></td>
<td>$8,000/$16,000 Single/Family</td>
<td>$5,250/$10,500 Individual/Family</td>
</tr>
<tr>
<td><strong>Initial/Medical</strong></td>
<td>$4,000/$6,000 Single/Family</td>
<td>$3,750/$7,500 Individual/Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket</strong></td>
<td>$8,000/$16,000 Single/Family</td>
<td>$5,250/$10,500 Individual/Family</td>
</tr>
<tr>
<td><strong>maxima</strong></td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Eligible medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>and Rx services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>after out-of-pocket</strong></td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>maxima are met</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Plus Plan family deductible: If more than one person is covered on the Plus Plan, the full family deductible must be met before benefits are paid.*
**prescription drug coverage**

Prescription Drug Coverage is provided by MedTrak. The cost of each prescription is determined by the tier it falls under. The three tiers are Generic, Preferred Drugs, and Non-Preferred drugs. You can find in-network pharmacies and a list of covered prescriptions at www.medtrakrx.com

**GENERIC DRUGS AND STEP THERAPY**

Generic drugs are the chemical equivalent of their more expensive brand name drug counterparts. Your plan uses a Step Therapy program designed to offer you the best medication at the lowest possible cost. With Step Therapy, your Plan will pay for the cost of certain lower-cost generic drugs initially (Step-One drugs), but not their higher cost brand alternatives (Step-Two drugs), unless medically necessary.

### Prescription Drug Tier Pricing

<table>
<thead>
<tr>
<th></th>
<th>Plus Plan</th>
<th>Basic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Retail Rx (30 day supply)</td>
<td>*after deductible is met</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% up to $200</td>
<td>20% up to $200</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>20% up to $300</td>
<td>20% up to $300</td>
</tr>
<tr>
<td>In-Network Mail Order Rx (90-day supply at Retail or Mail Order)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% up to $500</td>
<td>20% up to $500</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>20% up to $750</td>
<td>20% up to $750</td>
</tr>
<tr>
<td>Specialty Rx – Best-In-Class (30 day supply)</td>
<td>20% up to $300</td>
<td>20% up to $300</td>
</tr>
<tr>
<td></td>
<td>100% of cost of eligible Rx fills apply towards the deductible, then Rx copays apply</td>
<td>Rx Copays count towards Rx out-of-pocket</td>
</tr>
</tbody>
</table>
dental insurance

A confident smile starts with oral health. The dental plans offered to you by Columbia Public Schools through Ameritas make it easy for you and your family to take care of your smiles. As with all other coverage, it’s important to stay in-network. Before each appointment, verify your dentist is still in Ameritas’ network and be sure to present your Ameritas ID Card to your dentist each visit.

If your dentist recommends services other than a preventive cleaning, ensure you ask for and receive a pre-treatment estimate before the work is performed. This will avoid any misunderstanding of Ameritas benefit payment amounts.

benefit summary

<table>
<thead>
<tr>
<th>Service:</th>
<th>Plan Pays:</th>
<th>Deductible - Individual/Family (3+ members)</th>
<th>Annual Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive/Diagnostic</td>
<td>100%</td>
<td>$100/$300</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Basic- Filling, Extractions, Root Canals</td>
<td>75% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major- Crowns, Bridges, Dentures</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic coverage</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

premiums

<table>
<thead>
<tr>
<th></th>
<th>35+ Hours per Week</th>
<th>30-34 Hours per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$31 – District Paid</td>
<td>$4.34</td>
</tr>
<tr>
<td>+ Spouse/Domestic Partner</td>
<td>$31</td>
<td>$31</td>
</tr>
<tr>
<td>+ Children</td>
<td>$49</td>
<td>$49</td>
</tr>
<tr>
<td>+ Spouse/Dom.Part. &amp; Children</td>
<td>$80</td>
<td>$80</td>
</tr>
</tbody>
</table>
vision

vision insurance

Eyesight is critical to your overall health. Did you know that a regular eye exam can detect high-cholesterol or even a brain-tumor? Columbia Public Schools offers you vision insurance through NVA.

Annual preventive eye exams are covered under the vision plan. Make sure to stay in-network. When you schedule your appointment, verify your provider is in NVA’s network.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit www.e-nva.com or contact NVA’s Customer Service Dept at 1-800-672-7723.

benefit summary

<table>
<thead>
<tr>
<th>Service (In-Network)</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam – once per calendar year</td>
<td>Covered 100% $10 copay</td>
</tr>
<tr>
<td>Lenses – once per calendar year</td>
<td>Standard Glass or Plastic Covered 100% After $10 copay</td>
</tr>
<tr>
<td>Single vision, bifocal, trifocal, lenticular</td>
<td>Covered at 100% for children under 19</td>
</tr>
<tr>
<td>Polycarbonates</td>
<td></td>
</tr>
<tr>
<td>Frames – once every two calendar years</td>
<td>Retail allowance up to $150 (20% discount off balance)</td>
</tr>
<tr>
<td>Contact Lenses – once per calendar year</td>
<td>In lieu of lenses</td>
</tr>
</tbody>
</table>

 premiums

<table>
<thead>
<tr>
<th></th>
<th>35+ Hours per Week</th>
<th>30-34 Hours per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$5.76</td>
<td>$5.76</td>
</tr>
<tr>
<td>+ Spouse/Domestic Partner</td>
<td>$11.53</td>
<td>$11.53</td>
</tr>
<tr>
<td>+ Children</td>
<td>$18.44</td>
<td>$18.44</td>
</tr>
<tr>
<td>+ Spouse/Dom.Part. &amp; Children</td>
<td>$21.34</td>
<td>$21.34</td>
</tr>
</tbody>
</table>
hsa

A health savings account allows you to set aside money on a pretax basis to pay for qualified expenses, such as doctor visits, prescriptions, braces, or even Lasik eye surgery, with tax-free dollars.

There is no use it or lose it rule with HSAs. Any remaining balance at the end of the year will roll over into the next plan year. HSAs are also portable. This means that if you were to change jobs or health plans, the money in your account stays with you.

One of the best parts of the HSA is its triple-tax advantage: tax-free deductions when you contribute to your account, tax-free investment earnings, and tax-free withdrawals for qualified medical expenses.

You must open your HSA Account with Landmark Bank. You will receive a card linked to your account to pay for qualified expenses. You may be penalized or taxed if you use your HSA funds to pay for ineligible expenses. Qualified expenses include prescriptions, contact lens fitting, orthodontia, acupuncture, artificial teeth, eye glasses, or other expenses that apply towards your deductible. A full list of qualified expenses can be found on the IRS website. Keep all receipts from HSA expenses and associated documentation to prove HSA funds were used for qualified medical expenses. Only medical expenses incurred after your HDHP effective date and the date your HSA is established are considered eligible expenses for reimbursement.

ELIGIBILITY

- You are covered under a qualifying high deductible health plan on the first day of the month
- You have no other health coverage except what is permitted by the IRS
- You aren’t enrolled in Medicare, Tricare or another medical plan which provides first dollar coverage
- You can’t be claimed as a dependent on someone else’s tax return
- You do not a have a health flexible spending account or health reimbursement account within your household

2019 IRS CALENDAR YEAR CONTRIBUTION LIMITS

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family</th>
<th>Age 55+ Catch Up</th>
<th>Columbia Public Schools Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,500</td>
<td>$7,000</td>
<td>$1,000</td>
<td>$56 for each full month enrolled, up to $672 annually</td>
</tr>
</tbody>
</table>

Tip

You can make additional pre-tax contributions to your HSA through payroll contributions. The account must be set up by the 15th of the month of hire to receive District contribution.
fSA

A Flexible Spending Account, or FSA, is an account set-up by your employer that allows you to pay for medical, dental, vision and dependent care expenses on a pre-tax basis. Pre-tax means before federal, state, and social security taxes are deducted from your paycheck. Refer to the IRS website for a full list of qualified and unqualified expenses. Our FSA Administrator is ASI Flex.

IMPORTANT DATES

• You must incur eligible expenses by December 31 of the Plan year.
• Claims must be filed no later than March 31 of the following year.

HEALTH CARE FSA

• Access to entire amount of money you set aside for the plan year on the first day of the plan
• “Use it or lose it” – Forfeit any money remaining in the account at the end of the plan year

LIMITED-PURPOSE FSA

• Allows you to use pre-tax dollars to pay for qualified dental and vision expenses, rather than using your HSA funds for those expenses
• May be used only if enrolled in an HSA

DEPENDENT CARE FSA

• Use pre-tax income for dependent care for children under the age of 13 who are being cared for while you or your spouse are working or seeking employment.
• Eligible dependents could also include a spouse or other IRS dependent who is mentally or physically disabled.
• Qualified expenses include daycare and at-home care services. Ineligible expenses include tuition for kindergarten or private schools, sports camps, or overnight camps.

ELIGIBILITY

• You are not required to participate in medical, dental, or vision plans sponsored by Columbia Public Schools in order to enroll in an FSA.
• New employees must enroll in the plan within 31 days of their hire date. At open enrollment, you re-elect your annual FSA contribution.

2019 IRS CALENDAR YEAR CONTRIBUTION LIMITS

<table>
<thead>
<tr>
<th>Traditional Flex</th>
<th>Dependent Care</th>
<th>Limited Flex</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,650</td>
<td>$5,000</td>
<td>$2,650</td>
</tr>
</tbody>
</table>
life insurance

When the unthinkable happens, you want to know your family is covered. Columbia Public Schools provides full-time employees with life and accidental death and dismemberment (AD&D) insurance through Kansas City Life, and pays the full cost of this benefit. You also have the option to purchase supplemental life insurance through Kansas City Life.

BASIC LIFE INSURANCE

Columbia Public Schools provides full-time employees enrolled in the medical program with $25,000 term life insurance. Part-time employees in the medical plan will pay a pro-rated premium. Life insurance provides you with the piece of mind knowing that if you are no longer able to financially provide for your family due to death that they will receive some financial benefit.

ACCIDENTAL DEATH & DISMEMBERMENT

The policy doubles ($50,000) upon death due to accident.

If you suffer a covered accidental injury such as loss of speech and hearing, quadriplegia, paraplegia, loss of limb, or thumb and index finger, you would be the beneficiary of a benefit (based on the type of loss).

SUPPLEMENTAL LIFE INSURANCE

Voluntary life insurance is available to supplement your employer paid life benefit. You can elect increments between $10,000 and $25,000. Guaranteed issue if you are a new hire.

SUPPLEMENTAL LIFE INSURANCE PREMIUMS

<table>
<thead>
<tr>
<th>Amount</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$2.20 per month</td>
</tr>
<tr>
<td>$15,000</td>
<td>$3.30 per month</td>
</tr>
<tr>
<td>$20,000</td>
<td>$4.40 per month</td>
</tr>
<tr>
<td>$25,000</td>
<td>$5.50 per month</td>
</tr>
</tbody>
</table>

tip

Make sure your beneficiary is clearly identified on all survivor benefit insurance documents.
disability

Columbia Public Schools provides employees working 20 hours or more per week with access to short-term and long-term disability income benefits. Both LTD and STD coverage is provided through The Hartford.

In the event you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers’ compensation benefits.

SHORT-TERM DISABILITY (STD)

Short-Term Disability provides you with a specified percentage of your pre-disability income. Typically, it provides coverage for 6 months or less. Conditions that can trigger STD are usually temporary in nature, such as pregnancy, broken bones, sprains, or minor surgery. Most people use accumulated sick time to cover the waiting period (4 weeks).

LONG-TERM DISABILITY (LTD)

Long-Term Disability, provides you with a percentage of pre-disability income. This type of policy provides protection for a longer period of time, sometimes to age 65. LTD is often used in situations of a catastrophic disease or illness.

These policies usually start when a short term policy ends. In a long term policy, you are usually defined as disabled if you cannot complete the duties of your own occupation for a first initial period, such as the first two years. After the initial period, you are defined as disabled if you cannot complete the duties of any occupation to which you are suited by education, training, or experience, for the remainder of the benefit period.

<table>
<thead>
<tr>
<th></th>
<th>Short-term Disability</th>
<th>Long-term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elimination Period</strong></td>
<td>30 days</td>
<td>180 days</td>
</tr>
<tr>
<td><strong>Duration of Benefit</strong></td>
<td>22 weeks (unless a result of pre-existing condition, then 4 weeks) (pregnancy is a pre-existing condition)</td>
<td>To Normal Retirement age, or a maximum of 42 months (dependent on age at time of disability)</td>
</tr>
<tr>
<td><strong>Percentage of Income Replacement</strong></td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Maximum Benefit</strong></td>
<td>$750 per week</td>
<td>$5,000 per month</td>
</tr>
</tbody>
</table>
retirement benefits

Certified Employee Retirement

All full-time certified employees are required by state law to participate in the Public School Retirement System of Missouri (PSRS). You pay 14.5% of your salary plus insurance costs to the retirement system, and the District matches your contribution. If hired after April 1, 1986, you also pay 1.45% in Medicare taxes. Part-Time certified staff working 17 hours per week have the option of Teacher or Non-Teacher retirement.

Non-Teacher Retirement

All non-certified staff working 20 hours a week or more, and eligible part-time staff members not participating in the Teacher Retirement program, are required by state law to participate in the Public Education Employee Retirement System (PEERS). You pay 6.86% of your salary plus insurance costs to the retirement system, and the District matches your contribution. You pay 7.65% for Social Security & Medicare taxes.

Contact PSRS/PEERS about your eligibility to purchase whole or partial years of service credit to help build your retirement.

Voluntary Retirement - TIAA

Participating in the 403(b) and 457(b) Plans makes it easy to put away money on a before tax basis to accumulate the dollars you need to purchase years of service credit. There are no tax penalties when using 403(b)/457(b) money to purchase years of service.

The District offers three voluntary retirement plans with TIAA. You can maximize your retirement income through payroll contributions. You may enroll, change, or cancel your contributions at any time in the 403(b), 403(b)Roth and/or 457(b) Plans.

The money you contribute is deducted from your gross wages before federal and state income taxes are calculated, except for Roth. All contributions are invested in a tax deferred vehicle of your selection. Your investment choices include fixed income and various mutual funds. Any increases in funds grow tax-free until the time you elect to withdraw them.
### retirement benefits

<table>
<thead>
<tr>
<th>Choice of Two Plans</th>
<th>457(b) and 403(b) Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions made pre-tax</td>
<td>Yes</td>
</tr>
<tr>
<td>Tax-deferred accumulation</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual contribution limits up to 100% of includable compensation</td>
<td>2019 - $19,000</td>
</tr>
<tr>
<td>Over age 50 addition to annual contribution limits</td>
<td>2019 - $6,000</td>
</tr>
</tbody>
</table>
| Over 15 years of service catch-up with current employer | 457(b) – None  
403(b) – Up to $3,000 per year additional, $15,000 lifetime total |
| Vesting | 100% immediate |
| Surrender charges | 457(b) – None  
403(b) – Based on contract provisions |
| Withdrawals prior to age 59 ½ | 457(b) – No penalties  
403(b) – Potential 10% penalty |
| Rollovers permitted | Yes |
| Loans | 457(b) – Yes  
403(b) – Yes |
| Investments | Fixed accounts and various mutual funds |
| Investment advisors | TIAA advisors and TIAA authorized local advisors |
| Purchase years of service with PSRS/PEERS | Yes |

You may enroll, change or cancel your contributions at any time.

### Enroll online in just a few easy steps:

1. Go to [www.TIAA.org/cpsk12](http://www.TIAA.org/cpsk12)
   - Click Ready to Enroll
   - Choose your plan(s) and then click Next
   - Select Begin Enrollment to be taken to the Welcome page
   - Register with TIAA to create your User ID and password

2. Complete a salary reduction agreement (SRA) form to advise payroll how much to deduct from your paycheck and when to begin the deduction. Return the completed SRA form to the Employee Benefits office in Business Services prior to the payroll deadline. Forms are found at: [www.cpsk12.org/TIAA](http://www.cpsk12.org/TIAA)

3. Follow the prompts and print the confirmation page. You are now enrolled.
employee assistance program

Columbia Public Schools cares about you and your family’s total well-being. That’s why Columbia Public Schools provides an Employee Assistance Program (EAP) at no cost to you. Administered by Boone Hospital, the EAP is a free and confidential service designed to help employees and families with personal or work/life balance issues.

SOME OF THE ISSUES EAP ADDRESS

• Resiliency
• Emotional wellness
• Workplace success
• Wellness and balance
• Personal and family goals
• Financial stress

EAP CONTACT INFORMATION

(573) 815-6034
(877) 327-0327
www.boone.org/eap

leave benefits

SICK LEAVE

• Full-time 12 month staff receive 10 days of sick leave per year.
• 9, 10, and 11 month staff receive a pro-rated share of 10 days.
• Part-time staff receive a pro-rated share based on their full-time equivalent (FTE).

VACATION LEAVE

• Full-time 12 month staff earn one day of vacation at the end of each full month of employment.
• Part-time 12 month staff receive a pro-rated share based on their full-time equivalent (FTE).

PERSONAL LEAVE

• Full-time 12 month staff receive 5 paid personal days at the beginning of each year.
• Part-time staff receive a pro-rated share based on their full-time equivalent (FTE).
• At year end, any unused personal leave will be converted to sick leave.
workers’ compensation

Pursuant to state law, an employee of CPS who is injured, killed or exposed to and contracts an occupational disease arising out of and in the course of employment is eligible for compensation in accordance to Missouri Workers’ Compensation Law, Chapter 287, RSMo.

ALL incidents and injuries are to be reported IMMEDIATELY

• Report all incidents and injuries within 24 hours to your supervisor or:
  • Dana Jones, CPS Occupational Health Nurse, Aslin Bldg
    Office (573) 214-3723
    Cell (573) 239-1772
• For Minor Injury: Call Dana for appointment.
• For Minor After Hours: Leave a message and Dana Jones will respond the following morning.
• For Severe Injury: Employees are required to go to MU Urgent Care.
  • Sunday thru Saturday, 8am – 8pm
  • South Providence Medical Park, 551 E. Southampton Drive
• For Severe After Hours: Report to Emergency Dept at University Hospital and Clinics
• If treatment for a work comp related incident/injury is sought elsewhere, the workers’ compensation program will not pay for those services, nor will any other insurance plan.
• All employees injured on the job must complete an Employee Injury/Incident Report, even if the employee does not need immediate medical care. This report must be completed in the employee’s handwriting and explaining how the incident occurred.
• Employees requiring treatment will receive a “Return to Work” form by the treating worker’s compensation doctor. This form must be presented to supervisor prior to reporting back to work.
• If possible, employees who are given restrictions by the doctor will be provided work duties as recommended by the physician and in consultation with the employee’s supervisor.
PART A: General Information
When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% of your household income for the year, 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:
Columbia Public Schools Employee Benefits
1818 W. Worley Street, Columbia, MO 65203
573-214-3710
www.cpsk12.org/benefits

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.
Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - Some employees. Eligible employees are: Employees working 30+ hours per week
  - With respect to dependents:
    - We do offer coverage. Eligible dependents are: Legal Spouse, Domestic Partners, Dependent Children of the Eligible Employee and Dependent Children of the Domestic Partner. Eligible dependents are covered to age 26.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.
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 –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td></td>
</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
</tr>
</tbody>
</table>

| Website: [http://www.indianamedicaid.com](http://www.indianamedicaid.com) |
| Phone 1-800-403-0864 |

<p>| Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> |
| Phone: 1-877-438-4479 |
| All other Medicaid |
| Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> |
| Phone 1-800-403-0864 |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLORADO</td>
<td>Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>1-800-221-3943/ State Relay 711</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health First Colorado Member Contact Center: <a href="http://www.kdheks.gov/hcf/">1-800-221-3943/ State Relay 711</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHP+: Colorado.gov/CHPF/Child-Health-Plan-Plus</td>
<td></td>
</tr>
<tr>
<td>IOWA</td>
<td>Medicaid</td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
<td>1-888-346-9562</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>1-800-359-1991</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td></td>
</tr>
<tr>
<td>MAINE</td>
<td>Medicaid</td>
<td>Medicaid Phone: 1-888-695-2447</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY: Maine relay 711</td>
<td></td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
<td>Website: <a href="https://www.dhhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://www.dhhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
<td>603-271-5218</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid and CHIP</td>
<td>Hotline: NH Medicaid Service Center at 1-888-901-4999</td>
<td></td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td></td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Medicaid</td>
<td>Medicaid Phone: 609-631-2392</td>
<td></td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>Medicaid</td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td></td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td>CHIP Phone: 1-800-701-0710</td>
<td></td>
</tr>
<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td>Medicare Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td></td>
</tr>
<tr>
<td>OREGON</td>
<td>Medicaid</td>
<td>Medicaid Phone: 609-631-2392</td>
<td></td>
</tr>
<tr>
<td>MONTANA</td>
<td>Medicaid</td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td></td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td>CHIP Phone: 1-800-701-0710</td>
<td></td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
<td>(855) 632-7633</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td>Lincoln: (402) 473-7000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Omaha: (402) 595-1178</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Medicaid Website</td>
<td>Medicaid Phone</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>NEVADA – Medicaid</td>
<td><a href="https://dhcfp.nv.gov">https://dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
<td></td>
</tr>
<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
<td></td>
</tr>
<tr>
<td>SOUTH DAKOTA – Medicaid</td>
<td><a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>1-888-828-0059</td>
<td></td>
</tr>
<tr>
<td>WASHINGTON – Medicaid</td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>1-800-562-3022 ext. 15473</td>
<td></td>
</tr>
<tr>
<td>TEXAS – Medicaid</td>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
<td>1-800-440-0493</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>U.S. Department of Labor</th>
<th>U.S. Department of Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits Security Administration</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td><a href="http://www.dol.gov/agencies/ebsa">www.dol.gov/agencies/ebsa</a></td>
<td><a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></td>
</tr>
<tr>
<td>1-866-444-EBSA (3272)</td>
<td>1-877-267-2323, Option 4, Ext. 61565</td>
</tr>
</tbody>
</table>

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.
Notice of Special Enrollment Rights

If you work more than 35 hours per week and are declining coverage for your dependents or work 30-34 hours per week and are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you work more than 35 hours per week and are declining coverage for your dependents or work 30-34 hours per week and are declining enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact
Columbia Public Schools Employee Benefits
1818 W. Worley Street, Columbia, MO 65203
573-214-3710
www.cpsk12.org/benefits
Women's Health and Cancer Rights Act Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (800) 990-9058.

Annual Notice

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (800) 990-9058 for more information.
Mental Health Parity and Addiction Equity Act Disclosure

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Columbia Public Schools Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (800) 990-9058.
Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
Medicare Part D Creditable Coverage Notice
Important Notice About Your Prescription Drug Coverage and 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 your Columbia Public Schools 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:

1. 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.

2. Your Columbia Public Schools has determined that the prescription drug coverage offered by the Columbia Public Schools 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. Because 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.

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 Columbia Public Schools coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Columbia Public Schools coverage, be aware that you and your dependents will be able to get this coverage back.

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 with your Columbia Public Schools 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 nineteen 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.

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 15th to December 7th.

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.
For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information call your benefit administrator. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Columbia Public Schools 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 about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 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).
Columbia Public Schools Employee Benefits
1818 W. Worley Street, Columbia, MO 65203
573-214-3710
www.cpsk12.org/benefits
Genetic Information Nondiscrimination Act (GINA) Disclosures
Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
General Notice of COBRA Rights
Continuation Coverage Rights Under COBRA

Introduction
You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
• The end of employment or reduction of hours of employment;
• Death of the employee;
• The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).
For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Columbia Public Schools Employee Benefits
1818 W. Worley Street, Columbia, MO 65203
573-214-3710
www.cpsk12.org/benefits

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Columbia Public Schools Employee Benefits
1818 W. Worley Street, Columbia, MO 65203
573-214-3710
www.cpsk12.org/benefits
General FMLA Notice
Employee Rights Under the Family and Medical Leave Act
The United States Department of Labor Wage and Hour Division

Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

• The birth of a child or placement of a child for adoption or foster care;
• To bond with a child (leave must be taken within 1 year of the child’s birth or placement);
• To care for the employee’s spouse, child, or parent who has a qualifying serious health condition;
• For the employee’s own qualifying serious health condition that makes the employee unable to perform the employee’s job;
• For qualifying exigencies related to the foreign deployment of a military member who is the employee’s spouse, child, or parent.

An eligible employee who is a covered service member’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer’s normal paid leave policies.

Benefits & Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual’s FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

• Have worked for the employer for at least 12 months;
• Have at least 1,250 hours of service in the 12 months before taking leave;* and
• Work at a location where the employer has at least 50 employees within 75 miles of the employee’s worksite.

*Special “hours of service” requirements apply to airline flight crew employees.
Requesting Leave

Generally, employees must give 30-days’ advance notice of the need for FMLA leave. If it is not possible to give 30-days’ notice, an employee must notify the employer as soon as possible and, generally, follow the employer’s usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee’s need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243)
TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

For additional information, including to request FMLA leave, please contact:
Columbia Public Schools
Human Resources
1818 West Worley Street
Columbia, MO 65203
573-214-3423
USERRA Notice Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act
USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:
- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation
If you:
- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

Then an employer may not deny you:
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement
- The U.S. Department of Labor, Veterans’ Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans’ Employment and Training Service, 1-866-487-2365.