2024 Benefits Guide

Your Health & Wellness

Columbia PUBLIC SCHOOLS

Contents

The information in this Enrollment Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage, and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any express or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact the Employee Benefits office. ©Marsh & McLennan Agency. All rights reserved.

Welcome to Your 2024 Benefits!

Columbia Public Schools is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

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

Eligibility

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. You may also enroll your eligible dependents for coverage. Eligible dependents include:

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

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

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental, vision, or Health Care or Dependent Care Flexible Spending Accounts unless you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you need to enter the "Life Event" in your Benefitfocus profile within 31 days of the event and make the desired changes, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

How to Enroll

Open enrollment for the 2024 plan year is **October 9th to October 20th**. If you are a new hire, you have 31 days to enroll from your date of hire.

Before You Enroll

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Select, review and submit your desired coverage.
- Be sure to complete beneficiary information for Life and AD&D benefits.

Check with Employee Benefits if you have questions.

Benefitfocus Enrollment Instructions

To enroll, simply follow the prompts within the portal:

- Log in to the CPS Portal, then click on the Benefitfocus icon
- From the Benefitfocus landing page, click on the Get Started icon.
- Complete the first few prompts regarding contact information.
- The enrollment platform will then walk you through all available coverages and associated steps.
- 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.
- When your elections are complete, click the "complete enrollment" icon.
- After you have submitted your enrollment, you will see a summary page of your elections. You may print this summary page

Staying Connected Year Round

Teladoc

Under the weather and need a fast doctor visit? Telemedicine gives you 24/7 access to U.S. board-certified doctors through the convenience of your phone. You and a practitioner can speak or video chat to answer questions, make a diagnosis and even prescribe some medications. This convenient and affordable option provides you on-demand access to treat many medical conditions. As always, call 911 for any emergency.

Telemedicine is provided through UMR and can be accessed by downloading the app or calling 800-835-2362. For more information visit website www.teladoc.com.

Medical

Columbia Public Schools' medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, on the Basic PPO Plan, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Before You Enroll

Consider this:

1. Think about the out-of-pocket expenses you will incur and your possible future medical expenses.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting the www.umr.com. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.
4. Evaluate how your out-of-pocket expenses may fluctuate and consider adding accident and/or hospital indemnity insurance to help offset your out-of-pocket medical costs.

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

	Plus Plan	Basic Plan
	United Healthcare Choice Plus	United Healthcare Choice Plus
	In-Network	In-Network
Deductible		
Individual	$2,000	$750
Family	$4,000	$1,500
Out-of-Pocket Maximum (Includes Deductible)		
Individual	$4,000 (Includes Rx)	$2,250
Family	$6,000 (Includes Rx)	$4,500
	You pay	You pay
Coinsurance	0%	20%
Preventive Care	No Charge	No Charge
Primary Care Physician	Deductible	Deductible then 20%
Specialist	Deductible	Deductible then 20%
Urgent Care	Deductible	Deductible then 20%
Emergency Room	Deductible	Deductible then 20%
Lab & X-ray	Deductible	Deductible then 20%
Hospitalization	Deductible	Deductible then 20%
Diagnostic Imaging (MRI/CT) –Prior Auth Required	Deductible	Deductible then 20%
Pharmacy		
Rx Out-of-Pocket	Deductible, then $2,000, in Rx copays	$1,500/$3,000
Retail Rx (up to 30-day supply)		
Tier 1	$10	$10
Tier 2	20%; Up to $200	20%; Up to $200
Tier 3	20%; Up to $300	20%; Up to $300
Tier 4	20%; Up to $300	20%; Up to $300
Mail Order Rx (90-day supply)	Tier 1-3: 2.5x Copay	Tier 1-3: 2.5x Copay
Medical Monthly Premiums		
Full-Time EE Only (35+ hrs)	$0	$0
Part-Time EE Only (30-34 hrs)	$85	$93
Spouse/Domestic Partner	$607	$663
One Child	$274	$299
Children (2+)	$474	$518
Spouse/Domestic Partner + One Child	$881	$962
Spouse/Domestic Partner + Children (2+)	$1,081	$1,181

Health Savings Account (HSA)

A Health Savings Account (HSA) is a personal savings account that you own and can use to pay for qualified out-of-pocket medical expenses. Your contributions to the HSA are taken out of your paycheck and are tax-free. Once you enroll in the HSA, you'll receive a debit card to pay for qualified out-of-pocket medical expenses. Your HSA can be used to pay for your health care expenses and those of your spouse and dependents, even if they are not covered by the High Deductible Health Plan (HDHP).

How a Health Savings Account (HSA) Works

Eligibility
Anyone who is:
- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not an High Deducible Health Plan (HDHP);
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return

Your Contributions
- You choose how much to contribute from each paycheck on a pretax basis.
- You can contribute up to the IRS maximum of $4,150/individual or $8,300/family.
- You can make an additional "catch-up" contribution of up to $1,000 per year if you are age 55 or older.

Columbia Public Schools' Contribution
- $56 for each full month of coverage. Up to $672 annually ($448 contributed in January and $224 contributed in September).

Eligible Expenses
You can use your HSA to pay for medical, dental, vision and prescription drug expenses incurred by you and your eligible family members. *Please note: Funds available for reimbursement are limited to the balance in your HSA.*

Using Your Account
Use the debit card linked to your HSA to cover eligible expenses — or pay for expenses out of your own pocket and save your HSA dollars for future health care expenses.

Your HSA is always yours – no matter what
One of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it the following year or at any time in the future. And if you leave the District or retire, your HSA goes with you.

The Triple Tax Advantage

HSAs offer three significant tax advantages:

1. You can use your HSA funds to cover qualified medical expenses, including dental and vision expenses — tax-free.
2. Unused funds grow and can earn interest over time — tax-free.
3. You can save your HSA dollars to use for your health care when you leave Columbia Public Schools or retire — tax-free.

If you want to save tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Year 1 Example: You enroll in the HDHP with HSA during enrollment		Year 2 Example: You enroll in the HDHP plan again next year
You contribute $4,150 for a total of $4,150		$3,450 rolls over from last year and you contribute $4,150 for a total of $7,600
You use the HSA to pay $700 of eligible expenses		You use the HSA to pay $1,250 of eligible expenses
You have $3,450 in the HSA to roll over to next year!		**You have $6,350 in the HSA to roll over to next year!**

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. There are three types of FSAs — the Health Care FSA, the Limited Purpose Health Care FSA and the Dependent Care FSA:

- **Health Care FSA** — Used to pay for out-of-pocket expenses associated with your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- **Limited Purpose Health Care FSA** — Used if you are enrolled in the HDHP medical plan. It works the same way as the standard Health Care FSA; however, you may only use it to pay for eligible vision and dental expenses.
- **Dependent Care FSA** — Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

You cannot use your Health Care FSA to pay for dependent care expenses, and you cannot use your dependent care FSA to pay for health care expenses.

Important: The IRS has a "use it or lose it" rule. If you do not spend all of the money in your FSA by the annual deadline, any unused dollars in your account(s) will be forfeited.

How the Health Care/Limited Purpose Health Care FSA Works	How the Dependent Care FSA Works
You may contribute up to $3,050 per year, pretax	You may contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns
You receive a debit card to pay for eligible medical expenses (funds must be available in your account)	You submit claims for reimbursement; no debit cards are provided
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses and over-the-counter medications prescribed by your doctor	Can be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs
Submit claims up to March 31 of the following year for expenses from January 1 to December 31	Submit claims up to March 31 of the following year for expenses from January 1 to December 31
If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations	If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations
Contribution limits for 2024 have not yet been released. An update will be provided by CPS when they are available.	

It's important to note that if you participate in a Health Savings Account (HSA), you may not participate in the Health Care FSA reimbursement account.

Dental

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures. Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents.

Columbia Public Schools offers dental coverage through Delta Dental. For information on finding a dental provider, visit www.deltadentalmo.com and click on Find a Provider.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

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

	Dental	
	In-Network / Premier	Out-of-Network
Deductible		
Individual	$50	$100
Family	$150	$300
Annual Maximum (excluding Ortho)		
	$1,500	
	You pay	
Preventive Care		
Exams, Cleanings, X-rays, Space Maintainers (under age 16), Fluoride Treatments (under age 19)	0%	0%
Basic Services		
Fillings, Sealants (under age 17), Extractions, Endodontics, Periodontics, Emergency Exams	20%	25%
Major Services		
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs, Once in 5 years	50%	50%
Orthodontia		
Adults	N/A	
Children (up to 19th birthday)	50%; Up to $1,500	
Dental Monthly Premiums	**35+ Hours per Week**	**30-34 Hours per Week**
Employee Only	$0*	$4.34
Employee + Spouse	$31	$31
Employee + Child(ren)	$49	$49
Employee + Family	$80	$80

*CPS pays the monthly premium of $31 for staff working a 35+ hour work week.

Vision

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents — or you may waive vision coverage.

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

Columbia Public Schools offers vision coverage through Eye Med. For information on finding a vision provider, visit www.eyemed.com and click on Find a Provider.

	Vision	
	In-Network	Out-of-Network
	You pay	Reimbursement
Cost		
Exam	$10	Up to $40
Materials	$10	See Below
Covered Services - Lenses		
Single Lenses	$10	Up to $30
Bifocals	$10	Up to $50
Trifocals	$10	Up to $70
Frames	$150 Allowance then 20% Off	Up to $105
Covered Services - Contacts in lieu of Frames/Lenses		
Contacts - Medically Necessary	$0	Up to $210
Contacts - Elective	$150 Allowance then 15% Off	Up to $105
Benefit Frequency		
Exams	Once Every 12 Months	
Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Contacts	Once Every 12 Months	
Vision Monthly Premiums	**30+ Hours Per Week**	
Employee Only	$5.43	
Employee + Spouse	$10.87	
Employee + Child(ren)	$17.38	
Employee + Family	$20.12	

Life and Accidental Death & Dismemberment (AD&D)

Life insurance, provided by New York Life Insurance Company, pays a lump-sum benefit to your beneficiaries to help meet expenses in the event you pass away. Accidental death and dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (such as loss of sight or the loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Life / AD&D Insurance – Employee Only

	Life and AD&D
Benefit Amount	$25,000
Evidence of Insurability / Proof of Good Health	$25,000
Age Reduction Schedule	None

Voluntary Life

Voluntary life insurance allow you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death or accidental serious injury.

Voluntary life insurance for you and your dependents, also provided by New York Life, can help protect your family during difficult times.

Voluntary Life Coverage

	Employee	Spouse	Child(ren) Up to Age 26
Benefit Amount	Increments of $10,000	Increments of $5,000	Increments of $1,000
Maximum	5x Salary; Up to $500,000	Not to Exceed Employee's Benefit; Up to $250,000	$10,000
Guarantee Issue	5x Salary; Up to $150,000	$25,000	$10,000

Guaranteed Issue (GI) and Evidence of Insurability (EOI)

Employees and spouses who elect coverage when they are first eligible may elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). Any coverage over the GI amount requires an EOI form for medical underwriting approval. If elected during Open Enrollment periods, EOI is required.

Before You Enroll

Consider this:

1. Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
2. It's important to understand any EOI rules that apply. If you enroll when you first become eligible, Voluntary Term Life Insurance for you and your spouse is guaranteed up to the amounts shown in the table. If you initially waive this coverage but want to enroll at a later date, you will need to provide satisfactory EOI before any coverage can take effect.
3. Think about who you want to designate as beneficiaries and make sure to name them as beneficiaries on your policy.

Voluntary Disability

Disability insurance can help you remain financially stable by providing a portion of your income if you become disabled and are unable to work. These benefits are provided through New York Life.

Short-Term Disability Benefits at a Glance	
Weekly Benefit	60% of Weekly Earnings
Weekly Maximum	$1,500 Per Week
Elimination Period	30 Days
Pre-Existing Limitation	6/12*
**Benefits may not be paid for any condition treated within six months prior to your effective date until you have been covered under this plan for 12 months.*	

Long-Term Disability Benefits at a Glance	
Monthly Benefit	60% of Monthly Earnings
Monthly Maximum	$10,000 Per Month
Elimination Period	180 Days
Pre-Existing Limitation	6/12*
**Benefits may not be paid for any condition treated within six months prior to your effective date until you have been covered under this plan for 12 months.*	

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within three months of the effective date of your insurance plan.

Evidence of Insurability

If you decline coverage when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI) — proof of good health — may be required before coverage is approved.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

Supplemental Benefits

Just like it sounds, supplemental benefits plans such as accident and hospital indemnity insurance can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary and are not medical insurance. Coverage is available for your spouse and children with most plans.

Most plans pay benefits regardless of any other insurance and benefits are paid directly to you, unless you specify otherwise. Benefits can help pay for expenses other insurance may not cover, such as out-of-pocket expenses, lost income, childcare, travel to and from treatment, home health care costs or regular household expenses.

Before You Enroll

Consider this:

1. What would happen if you had an accident or became seriously ill and became unable to work? Would you be covered financially?
2. These benefits provide a lump-sum payment that can help you cover unexpected medical expenses or make up for missed income.

Accident

Accident coverage is designed to provide a cash benefit in the event of a covered accident or injury. The plan will pay a set amount based on the injury suffered and treatment received, regardless of any other insurance.

Accident Monthly Rates	Mid	High
Employee Only	$7.98	$11.07
Employee + Spouse	$12.56	$17.44
Employee + Child(ren)	$13.67	$18.87
Employee + Family	$21.37	$29.53

Sample of Eligible Expenses	
 **Emergency Room Visits**	 **Hospital Stays**
 **Medical Exams** – Including major diagnostic exams	 **Physical Therapy**
 **Fractures and Dislocations**	 **Transportation and Lodging** – if you are away from home when the accident happens

Hospital Indemnity Insurance

Hospital Indemnity coverage is designed to provide a cash benefit in the event of a hospitalization and can help pay for expenses not covered by your medical plan. The plan will pay regardless of any other insurance.

Hospital Indemnity Monthly Rates	Mid	High
Employee Only	$14.48	$25.51
Employee + Spouse	$27.21	$47.82
Employee + Child(ren)	$27.53	$48.03
Employee + Family	$42.41	$74.07

Planning for Retirement

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.

Planning for Retirement

Contributions made pre-tax	Yes
Tax-deferred accumulation	Yes
Annual contribution limits up to 100% of includable compensation	$22,500 in 2023 $23,000 in 2024
Over age 50 addition to annual contribution limits	$7,500
Over 15 years of service catch-up with current employer	457 (b) – None 403 (b) – Based on contract provisions
Vesting	100% immediate
Surrender charges	457 (b) – None 403 (b) – Based on contract provisions
Withdrawals prior to age 59 ½	457 (b) – No penalties 403 (b) – Potential 10% penalty$
Rollovers permitted	Yes
Loans	Yes
Investment	Fixed accounts and various mutual funds
Investment advisors	TIAA advisors and TIAA authorized local advisors
Purchase years of service with PSRS/PEERS	Yes

Enroll online in just a few easy steps:

1. Go to 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 on the Employee Benefits website "Forms" page or by contacting the Employee Benefits office.
3. Follow the prompts and print the confirmation page. You are now enrolled.

Additional Benefits

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.

This program is available 24 hours a day, 365 days a year for confidential assistance and referral services with items such as:

- Managing stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Childcare issues — including identifying schools, daycare, tutors, and more
- Aging parents

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

EAP Contact Information

573-815-6034 or 877-327-0327

www.boone.org/eap

Additional Benefits-Medical

Emerging CARE

The support framework Emerging CARE focuses on the following key strategic elements to guide and support members:

- Frequent Emergency Room Visits
- Medical Specialty Drugs
- Inpatient and Outpatient Behavioral Health/Substance Use Disorder Support
- Adverse Determination and Appeal Support
- Pre-admission Counseling
- Discharge Support

The Emerging CARE team consists of both registered nurses and social workers. Our CARE Coordinators have many years of experience spanning multiple different specialties including general surgery, Behavioral Health/Substance Use Disorder, critical care and pediatrics.

CRS Enhanced Program

Benefits of the CRS Enhanced Program:

- Protects plan assets by basing reimbursement on a market-rate approach
- Reimbursement methodology is understood by providers
- Promotes member awareness of health care costs and encourages them to seek services from their PPO network providers
- Encourages providers to contract at a fair level of reimbursement

Important Contacts

Coverage	Administrator	Phone	Website
Teladoc	UMR Group: 76414028	(800) 835-2362	www.teladoc.com
Medical	UMR Group: 76414028	(844) 586-7311	www.umr.com
Pharmacy	Express Scripts Group: CPSDRX1	(800) 808-3734	www.express-scripts.com
Flexible Spending Accounts	ASI	(800) 659-3035	www.asiflex.com
Dental	Delta Dental	(800) 335-8266	www.deltadentalmo.com
Vision	EyeMed	(844) 873-7853	www.eyemed.com
Life/Vol Life/AD&D	New York Life	(888) 724-2262	www.newyorklife.com
Disability	New York Life	(800) 303-9744	www.newyorklife.com
Disability Insurance	New York Life	(888) 724-2262	www.newyorklife.com
Accident Insurance	The Hartford	(866) 547-4205	www.thehartford.com
Hospital Indemnity Insurance	The Hartford	(866) 547-4205	www.thehartford.com
Employee Assistance Program (EAP)	Boone Hospital	(573) 815-6034 (877) 327-0327	www.boone.org/eap
State Retirement	PSRS/PEERS	(800) 392-6848	www.psrs-peers.org
Voluntary Retirement	TIAA 403(b) & 457(b)	(800) 842-2638	www.tiaa.org/cpsk12

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don't contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

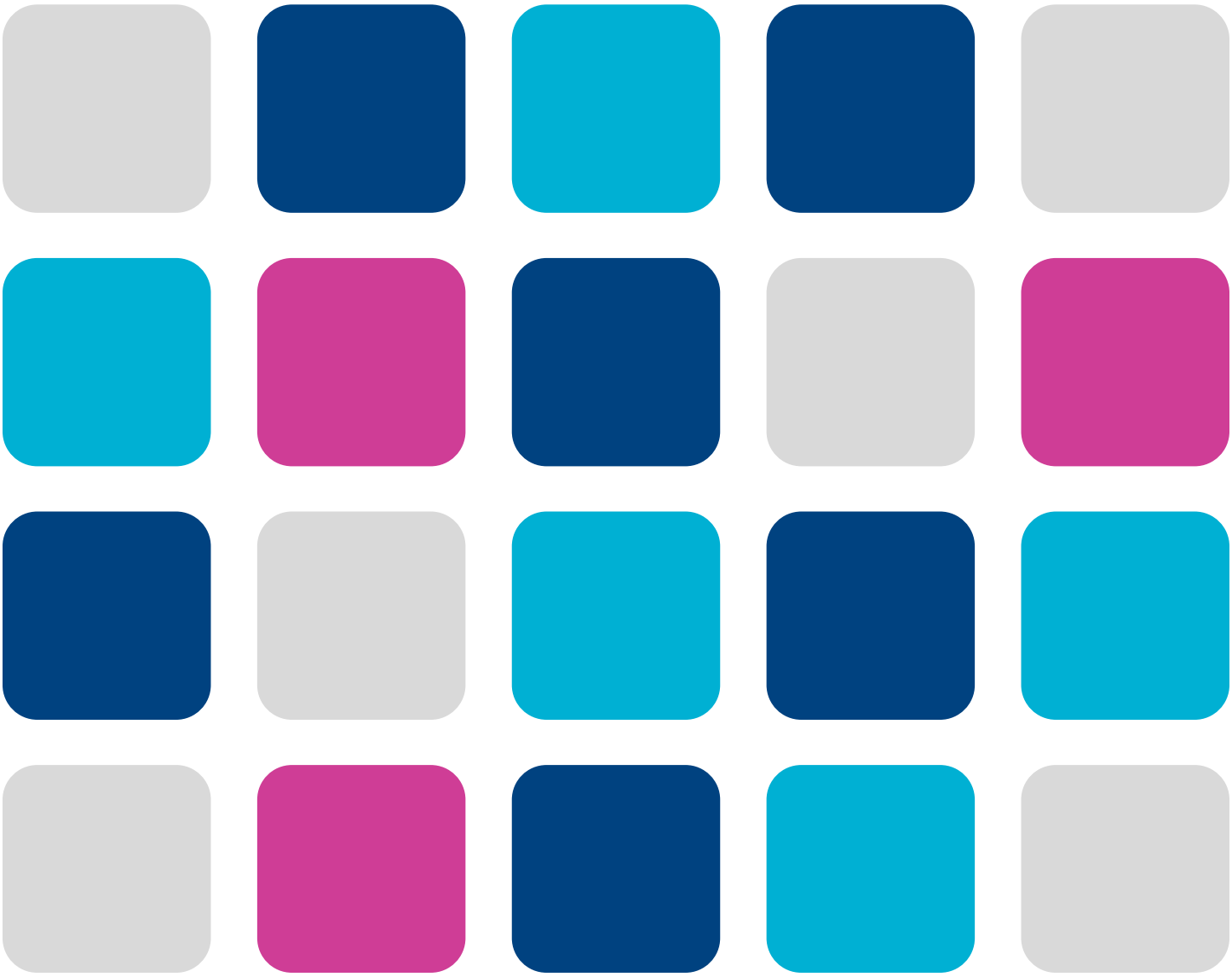
Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Notes



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