

2020

Benefits Enrollment Guide

Active Employees



**St. Louis Park
Public Schools**

Achieving success, one student at a time!

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The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Log on to Skyward Open Enrollment Portal.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?



Open Enrollment is the only chance to make changes, unless you experience a “change in status.”

PACKAGE OVERVIEW

ST. LOUIS PARK PUBLIC SCHOOL DIST. offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective July 1, 2020:

- Medical benefit plans with PreferredOne
- Dental benefit plans with Delta Dental
- Basic Life/AD&D, Voluntary Life/AD&D, Voluntary Short Term Disability and Long Term Disability benefit plans with The Standard
- VEBA/Flexible Spending Accounts with Genesis/TASC Employee Benefits, Inc.

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

St. Louis Park Schools Human Resources:
(952) 928-6000



MEDICAL PLANS

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

Carrier Name	PreferredOne			
Name of Plan	NationalONE \$20 Copay - Plan A		NationalONE \$1,000 Deductible - Plan B	
Type of Plan	PPO		PPO	
Office Visits	In Network	Out of Network	In Network	Out of Network
Primary	Primary: \$20 Copay Convenience Care: No Charge Virtuwell: No Charge for first three visits and thereafter	Deductible then 20%	Primary: Deductible then 20% Convenience Care: Deductible then 20% Virtuwell: No Charge for first three visits and thereafter	Deductible then 20%
Specialist	\$20 Copay	Deductible then 20%	Deductible then 20%	Deductible then 20%
Pharmacy				
Annual Rx Deductible	\$750/\$1,000	Covered at out of network benefit level. Please see plan design.	\$750/\$1,500	Covered at out of network benefit level. Please see plan design.
Retail Standard	Formulary: 25% up to \$40 Non-Formulary: Not Covered		Formulary: 25% up to \$40 Non-Formulary: Not Covered	
Retail Specialty	20%		20%	
Mail Order (90 days - Standard)	3x Copay		3x Copay	
Common Services				
In-Patient Facility	20% Coinsurance	Deductible then 20%	Deductible then 20%	Deductible then 20%
Out-Patient Facility	20% Coinsurance	Deductible then 20%	Deductible then 20%	Deductible then 20%
Urgent Care	\$20 Copay	Deductible then 20%	Deductible then 20%	Deductible then 20%
Emergency Room	\$100 Copay		Deductible then 20%	
Annual Medical Deductible				
Individual	Not Applicable	\$150	\$1,000	\$1,000
Family		\$300	\$2,000	\$2,000
Coinsurance	20%	20%	20%	20%
Annual Out of Pocket	Includes Deductible		Includes Deductible	
Individual	\$1,250	\$1,250	\$2,250	\$2,250
Family	\$2,500	\$2,500	\$3,500	\$3,500
Maximum Benefits	Unlimited - LTM		Unlimited - LTM	

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

All Benefit Eligible Employees. Please check with your HR representative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$5,000 (or \$2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION (VEBA)



What is a VEBA?

VEBA stands for Voluntary Employees' Beneficiary Association. It is a trust that is exempt from tax under the IRS code 501 (c) (9). The funds in a VEBA are used to reimburse participants for health care expenses. Health care expenses that are eligible for reimbursement are governed by Section 213(d) of the IRS Code.

ST. LOUIS PARK PUBLIC SCHOOLS VEBA

The VEBA plan option renews each July 1st.

For those employees that elect Plan B - \$1,000 Deductible Medical Plan (Plan B), St. Louis Park Public Schools will contribute \$1000 annually into the VEBA account. Please refer to your contract for more information. VEBA contributions are made only for active employees. An employee entering the plan after July 1st will receive a pro-rated VEBA contribution.

Any funds not used in the current plan year will roll over into the next plan year.

The VEBA plan is not a replacement for the Flexible Spending Account. Both these plans can be used together.

If you are currently enrolled or will be enrolling in the \$1,000 Deductible Medical Plan (Plan B) you are automatically enrolled in the VEBA plan and will receive a Welcome Kit from Genesis / TASC Employee Benefits.

Genesis / TASC Benefits Administers the VEBA Plan

More information may be obtained by emailing Customercare@genesisbenefits.net. You may also to gather and track your own data, usage details and obtain forms online at <https://mybenefitsportal.tasconline.com>

DENTAL PLANS

For this plan year, you can choose from the following dental options. Refer to the carrier benefits summaries for the exact benefit level associated with your plan choice.

Carrier Name	Delta Dental			
Name of Plan	Plan A - Delta Dental PPO/Premier		Plan B - Delta Dental PPO/Premier	
Network	PPO		PPO / Premier	
Class	In Network	Out of Network	PPO/Premier	Out of Network
Preventive	0%	Not Applicable	0%	0%
Basic Restorative	0%		Deductible then 20%	Deductible then 20%
Major Services	40%		Deductible then 50%	Deductible then 50%
Orthodontia	50%		50%	50%
Plan Details				
Deductible applies to Preventive	No	Not Applicable	No	No
Endodontics/Periodontics: Basic or Major	Basic		Basic	Basic
Orthodontics (Adult/Children)	Children		Children	Children
Deductible				
Person - Calendar Year	Not Applicable	Not Applicable	\$25	\$25
Family - Calendar Year			\$75	\$75
Plan Maximums				
Calendar Year Max	Unlimited	Not Applicable	\$1,000	\$1,000
Ortho Lifetime Max	\$1,500		\$1,000	\$1,000

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LIFE AND AD&D INSURANCE PLAN

Basic Life

Carrier Name	The Standard
Life Benefit	Based on Group's Contract
AD&D Benefit	Based on Group's Contract
Guaranteed Issue Amount	Based on Group's Contract
Conversion Privilege	Yes
Waiver of Premium	Yes

Voluntary Life

Carrier Name	The Standard
Employee Life and AD&D Benefit	Increments of \$10,000 to \$500,000 Maximum
Dependent Life and AD&D Benefit	Spouse: Increments of \$5,000 to \$250,000 Maximum not to exceed 100% of employee's amount; Child: \$5,000 or \$10,000
Conversion Privilege	Yes
Waiver of Premium	Yes

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DISABILITY INSURANCE

Voluntary Short Term Disability

Carrier Name	The Standard
Benefit	60%
Maximum Weekly Benefit	\$1,250
Waiting Period-Accident	7 Days
Waiting Period-Sickness	7 Days
Duration of Benefits	90 Days

Long Term Disability Provided by District

BENEFIT SCHEDULE	66 2/3%
MAX BENEFIT	\$7,500
WHO PAYS PREMIUM?	ER PAID (PRE-TAX) TAXABLE BENEFIT AT TIME OF PAYOUT
BENEFIT WAITING PERIOD	90 DAYS
OWN OCCUPATION	24 MONTHS

Did you know?



Over a billion people worldwide live with some form of disability- about 15% of world population.*

*Source: World Health Organization “www.who.int/features/factfiles/disability/en/”

EAP FOR ANYONE COVERED BY THE LTD:
3 SESSION MODEL
WEBSITE: [HTTP://WWW.WORKHEALTHLIFE.COM/STANDARD3](http://WWW.WORKHEALTHLIFE.COM/STANDARD3)
TOLL-FREE NUMBER: 888.293.6948

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EMPLOYEE ASSISTANCE PROGRAM (EAP)

ST. LOUIS PARK PUBLIC SCHOOL DIST. provides these services at no cost to employees or their families. No referrals are needed to see an EAP counselor, and you never have to worry about finding a provider who is in your network. And unlike insurance-covered care, you never have a co-pay. In addition, all household family members are covered regardless if they are covered by other benefits.

The call center is open 24 hours a day, 7 days a week. All operators have clinical backgrounds and at minimum a bachelor's degree in the field. You can also talk to a licensed counselor at any time. Instead of waiting weeks to be seen by a counselor, you can contact one anytime.

We offer short-term counseling to help people work through any problems they may be having. Some counseling sessions are done over the phone, while in other instances the employee visits the counselor.

Vital Worklife: Call 800-383-1908 or visit www.VITALWorkLife.com

The Standard: Call 888-293-6948 or visit www.workhealthlife.com/Standard3

- Stress Management
- Divorce/Marital Problems
- Grief
- Feeling Unmotivated
- Feeling Depressed
- Family Issues
- Feeling Stuck
- Drug and Alcohol Issues



The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

TELEMEDICINE



What is Telemedicine?

- Telemedicine uses technology to facilitate communication, between a doctor and patient who are not in the same physical location for medical evaluation, diagnosis and treatment.
- Speak to a real live doctor 24/7/365.
- All doctors are US Board Certified, licensed to practice medicine and write prescriptions in the state the caller is located in.
- Experienced doctors are here to help.
- 100% HIPAA Compliant.
- Designed for non-emergency care; 71 % of all medical visits today are non-emergency.

Benefits

- ✓ Remote Access
- ✓ Specialist Availability
- ✓ Cost Savings
- ✓ Convenient Care

For more information on how Telemedicine benefits may affect your HDHP plan with an HSA, please contact your Human Resources representative.

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EMPLOYEE DEDUCTIONS

ST. LOUIS PARK PUBLIC SCHOOL DIST. contributes to the cost of the medical plan for you and your family. To determine what you will pay per month look at your employee agreement for Health Insurance. Then subtract the amount District pays from the amount you owe. For example, if you are choosing Medical Plan B Employee only, and your contract says the District pays \$570 per month then the cost to you is \$698 - \$570= \$128/month.

Coverage Tier	Total Monthly Premiums
Medical Plan A	
Employee Only	\$781.00
Employee + 1	\$1,659.00
Family	\$2,310.00
Medical Plan B	
Employee Only	\$698.00
Employee + 1	\$1,478.00
Family	\$2,058.00
Dental Plan A	
Employee Only	\$54.27
Family	\$120.71
Dental Plan B	
Employee Only	\$47.19
Family	\$104.97

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

EMPLOYEE DEDUCTIONS

Employee Rates – Voluntary Life Insurance and Voluntary Short Term Disability

Age	Voluntary Life Rates	Voluntary Short Term Disability
0-29	\$0.060	\$0.356
30-34	\$0.080	\$0.374
35-39	\$0.100	\$0.207
40-44	\$0.160	\$0.125
45-49	\$0.280	\$0.126
50-54	\$0.460	\$0.133
55-59	\$0.730	\$0.173
60-64	\$1.140	\$0.218
65-69	\$2.060	\$0.218
70-74	\$3.710	\$0.218
75-99	\$3.710	\$0.218
Voluntary AD&D	\$0.015	

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

- 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 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 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

- In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy, including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.



REQUIRED CHIP NOTICE

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	FLORIDA – Medicaid Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GEORGIA – Medicaid Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

REQUIRED CHIP NOTICE (CONT)

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

REQUIRED CHIP NOTICE (CONT)

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

Paperwork Reduction Act Statement

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

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

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

HIPAA Notice



HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully-insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html>

Link to OneDigital's privacy policy: <https://www.onedigital.com/privacy-policy/>



Model Special Enrollment Notice

If you 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 the appropriate time period that applies under the plan after you 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 the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance>

For additional information on your employer's privacy policy, please contact your HR department.

CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

CARRIERS, VENDORS & CONTACTS

Program	Vendor	Contact Information
Medical/Rx	PreferredOne	763-847-4477 or 800-997-1750 www.preferredone.com
Dental	Delta Dental of Minnesota	651-406-5916 or 800-553-9536 www.deltadentalmn.org
Basic Life/AD&D, Voluntary Life/AD&D, Voluntary Short Term Disability and Long Term Disability	Standard	Life Insurance Phone Number: 800-628-8600 Long Term Disability Phone Number: 800-368-1135 www.Standard.com
Employee Assistance Program (EAP)	Standard Vital Worklife	888-293-6948 www.Workhealthlife.com/Standard3 800-383-1908 www.vitalworklife.com
VEBA/Flexible Spending Accounts	Genesis/TASC Employee Benefits, Inc.	866-678-8322 www.genesisbenefits.net
Healthy Savings Discount Program	Healthy Savings	www.healthsavings.com
Fitness Program	Wellbeats	866-736-6640 www.wellbeats.com

Know Where to Go!

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

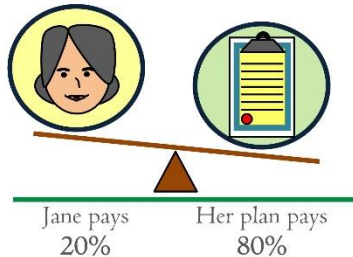
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* (See page 6 for a detailed example.) any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The health insurance or [plan](#) pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

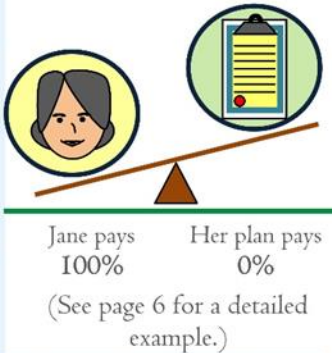
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don’t have [minimum essential coverage](#), you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered healthcare services. Your share is usually lower for [in-network](#) covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, [in-network](#) services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the [individual responsibility requirement](#). Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do **not** contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider”.

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the [plan](#) will usually pay 100% of the

[allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn’t cover. Some [plans](#) don’t count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.

Physician Services

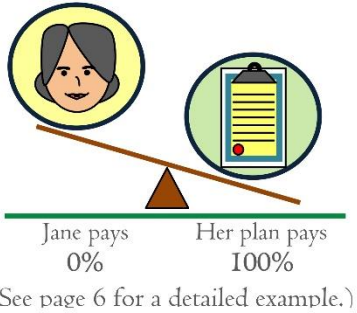
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "[health insurance](#)".

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called prior authorization, prior approval or precertification. Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your [health insurance](#) or [plan](#) will cover the cost.



Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan’s [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you’ll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

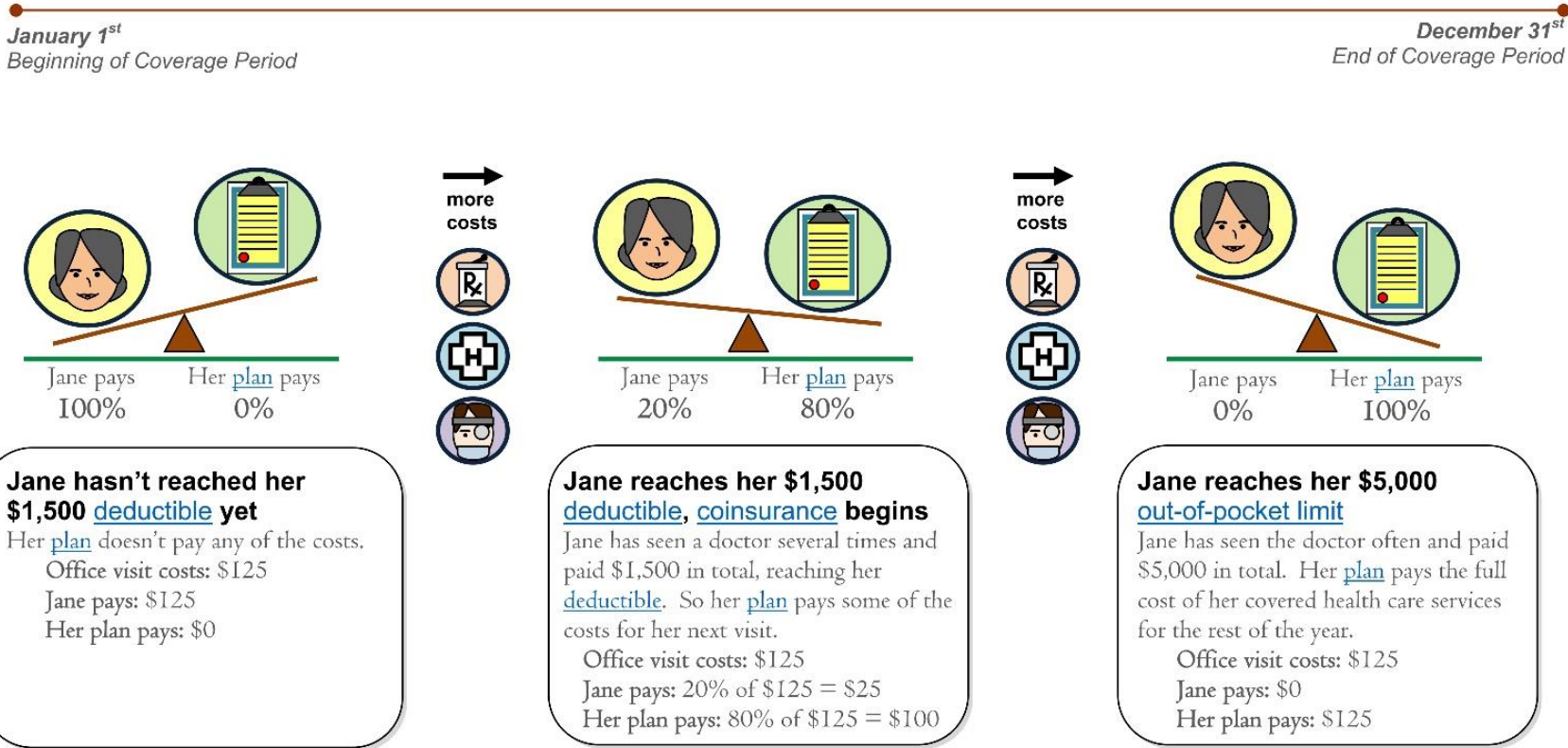
The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Coinsurance: 20% Out-of-Pocket Limit: \$5,000



Additional Benefit Information



Helping you and your family meet life's challenges

Whatever the issue confronting you or your family members, VITAL WorkLife can help.

Your Employee Assistance Program (EAP) includes:

- **Unlimited phone consultation:** Anytime, day or night
- **Face-to-face counseling:** Six sessions per incident with our national network of master's and doctorate level professionals
- **Nurse Peer Coaching:** If you or a family member are a nurse, you have access to one-on-one confidential phone coaching by nurses who have experienced similar work/life challenges
- **Educator Peer Coaching:** If you or a family member are a teacher, you have access to one-on-one confidential phone coaching by educators who have experienced similar work/life challenges
- **Legal services:** Free 30-minute consultation with an attorney by phone or in-person — discounted rates for further representation, in most cases
- **Financial services:** Unlimited phone consultations with a financial counselor
- **Identity theft prevention & support:** Comprehensive identity theft packet available upon request
- **Member website:** Online benefit information and extensive work and life resources
 - 5,000+ articles, assessments, audio files, calculators, checklists, resource links and more
 - Online Seminars
 - eLearning Courses



**Call 800.383.1908 or visit
VITALWorkLife.com**

Username: PreferredOne

Password: member



Pathways to Well Being

800.383.1908 | VITALWorkLife.com

30-115-0918



**A benefit employees
actually want to
work[out] for.**



Wellbeats is the on-demand fitness program that lets your employees work out however, whenever and wherever they like. Learn how Wellbeats can bring a more flexible, inclusive, and dynamic fitness experience to your employees all while giving you a more trackable, data-centric wellness option.

Why Wellbeats?

Wellbeats is trusted by 2,300+ clients with over 5 million class plays worldwide. Our comprehensive app technology delivers a fitness experience that is personalized for the user based on their interests and behaviors, ensuring long term, measurable engagement.

Inspiring, high-quality content

No equipment necessary

Relatable, highly certified instructors

Reliable, easy-to-use video streaming

Great for multiple locations and remote workers



Support your fitness program's success with Wellbeats

Wellbeats is a cost effective, scalable platform that integrates seamlessly into current wellbeing programs.

Easy to implement, administer and integrate

Knowledgeable client and technical support

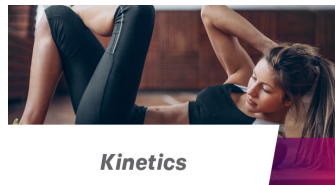
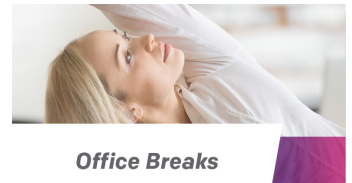
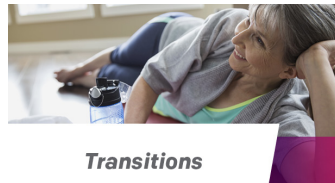
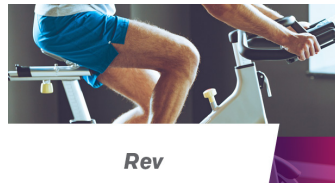
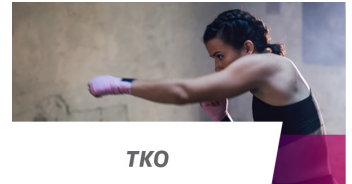
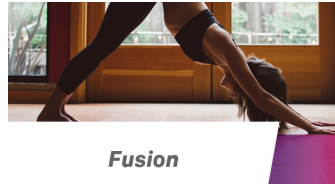
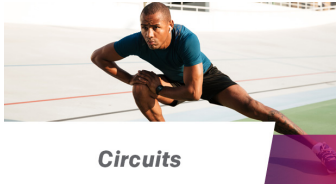
Turnkey marketing communications

Robust measurement and reporting



High-quality content and instructors

Wellbeats features goal based workout plans, fitness assessments and 400+ classes in nearly 30 channels. From yoga to cycle to office breaks, our videos span various lengths and difficulty levels.



Trusted brands trust Wellbeats

Case study: Seagate

Seagate integrated Wellbeats into their health benefit offerings, including weekly challenges and incentive program, allowing employees to earn premium reductions and gift cards.



After 16 months

22.8% Employee participation

287 minutes per month by engaged users

853K+ Activity minutes

297+ Class plays

4200 Enrolled work out plans

Wellbeats has shown me easy breaks to take at work and to get in short workouts during my day to stretch and relax from stress.

- Brian N. Seagate Employee



**TAKE CARE OF
YOUR BODY TODAY**
its where you live

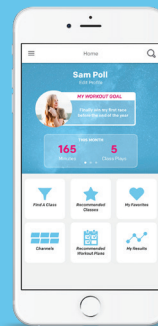
Ready? Set? Sweat.

No more gym memberships.

Wellbeats Virtual Fitness is an on-demand fitness provider that delivers fitness classes, workout plans and fitness assessment to users anytime, anywhere.

With Wellbeats, you stream personalized workout classes to your mobile device. There's something for every age, interest and fitness level. All workout plans feature a day-by-day calendar of recommended classes to accomplish common fitness goals.

**When you enroll with PreferredOne,
we'll send Wellbeats registration
details along with your new
PreferredOne member ID card.**



- ✓ Play Classes Remotely
- ✓ Track Workouts
- ✓ Recommended Classes
- ✓ Use Workout Plans
- ✓ Track Fit Tests

Wellbeats



Value Added Services:

Life Services Toolkit (available to those covered by basic life)

Question: Our Life Services Toolkit advertises “up to 6 face to face sessions” for the grief and loss support. (Is that separate from the 3 sessions included in the 3 session EAP model?)

Answer: The Life Services Toolkit is different from the EAP. Life Services Toolkit is tied to the Life insurance, those 6 sessions are available to a beneficiary only after a life claim. EAP is tied to LTD and it is a resource that’s available to anyone that is eligible to use the program at any time.

Available flyers:

- <https://www.standard.com/eforms/17527.pdf>
- <https://www.standard.com/eforms/17526.pdf>

Travel Assist (available to those covered by basic life):

About Generali Global Assistance

Generali Global Assistance is a worldwide travel assistance organization. It was established in 1963 as Europ Assistance. It was the first company to offer travel assistance services. The company started in France and quickly expanded, into other European countries. In the 80’s and 90’s it expanded around the world and grew to have over 30 offices globally. The US operations opened in 1983 with primary focus on Travel Assistance, and has since expanded to include Security and several other services.).GGA’s international footprint, network of partners, providers, and on-the-ground resources provide rapid response times and access to vetted local resources. The Generali Global Assistance US office operates under the Group’s global medical management unit GMMI, Inc.

Travel Assistance services will remain the same, in addition to the following benefits: Natural Disaster Evacuation Coordination, and Mobile Access via the Risk intelligence Portal. The name on all marketing materials will change to Generali Global Assistance, Travel Assistance Toll-Free numbers will change to (Travel Assistance: 866-455-9188) and (Extended Travel Assistance 866-455-9222). The web address for services will not change (you will continue to use www.standard.com/travel). Employees will continue to have access to services 24/7, UHCG will redirect callers to GGA after January 1, 2019, if a case is open prior to January 1, 2019 UHCG will continue to support that case until it’s closed.

- Travel Assistance Flyer: <https://www.standard.com/eforms/14684.pdf>

Health Advocacy Select (available to those out on a Short Term Disability claim)

In the event of a disabling medical condition, your employees will have access to a dedicated Personal Health Advocate. Their Personal Health Advocate – typically a registered nurse – can assist them with a wide range of services such as scheduling appointments, coordinating health care with providers and specialists, managing out of pocket medical expenses, resolving medical claims and billing issues, and finding resources for services that may not be covered through health insurance. Every new request will be handled by a dedicated Personal Health Advocate from the moment the case is assigned, until it's fully resolved.

Eligibility

Personal Health Advocates are available to all eligible employees ***who are out on a short term disability claim*** regardless of their occupation. Advocates are available Monday – Friday, 8 a.m. – 12 a.m. (midnight), Eastern time at 944.450.5543.

Next-Steps

To learn more about Health Advocate Select, please contact your Employee Benefits Representative or visit the following links:

- For employees: <https://www.standard.com/eforms/18390.pdf>
- For employees (In Spanish): <https://www.standard.com/eforms/18390spu.pdf>
- For employers: <https://www.standard.com/eforms/18391.pdf>



Employee Assistance Program (available to those covered by the LTD):

3 Session Model

Website: <http://www.Workhealthlife.com/Standard3>

Toll-free number: 888.293.6948

Information on EAP:

Standard Insurance Company works with a vendor, Morneau Shepell, to provide an Employee Assistance Program (EAP). The program offers a range of services available by telephone or in person to help employees and their household members. The services provided range from work life services, legal and financial counseling to face-to-face assessment and counseling sessions. These services are designed to prepare employees to face workplace challenges and to steer them toward success.

Flyers:

- <https://www.standard.com/eforms/17303.pdf> (20 ways EAP can Help)
- <https://www.standard.com/eforms/17201.pdf> (Our main EE EAP Brochure)
- <https://www.standard.com/eforms/17274.pdf> (Child Care Services)
- <https://www.standard.com/eforms/19075.pdf> (Elder Care Services)
- <https://www.standard.com/eforms/17277.pdf> (EAP Convenience Services)
- <https://www.standard.com/eforms/17302.pdf> (Coping with suicide)
- <https://www.standard.com/eforms/17245.pdf> (Debt and Credit Problems)
- <https://www.standard.com/eforms/17304.pdf> (Depression signs)
- <https://www.standard.com/eforms/17246.pdf> (Difficult Coworkers)
- <https://www.standard.com/eforms/17248.pdf> (Managing caregiver stress)
- <https://www.standard.com/eforms/17249.pdf> (Manage stress right now)
- www.standard.com/eforms/19312.pdf (Mobile App Flyer)
- <https://www.standard.com/eforms/17277.pdf> (Convenience Services)
- <https://www.standard.com/eforms/17301.pdf> (Cyber Bullying)
- <https://www.standard.com/eforms/17463.pdf> (Online Will and Legal Form Prep)
- <https://www.standard.com/eforms/17272.pdf> (EAP Resource Guide for People Managers)

Individual EAP face-to-face counseling services are not provided to dependent children under the age of 12. If a child under the age of 12 needs counseling assistance, the vendor will help coordinate a referral to a counselor in the covered employee's health insurance network. The reason for this is that EAP is a more general service and the counseling network is not comprised of specialists skilled in pediatric counseling.



St. Louis Park
Public Schools

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2. **Shop** for the promoted items at participating grocery stores including Cub, Lunds & Byerlys, Hornbacher's, and Rainbow.
3. **Scan** your Healthy Savings card during checkout and savings are instant!



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