Fitzgerald Public Schools
2021-2022 Benefit Enrollment Guide
Administrators and Professional Staff

Dear Fitzgerald Staff,

We believe that all employees should be covered by a great benefits package. Our benefits allow every employee and their qualified dependents to take advantage of our wellness program and not be worried when the unexpected happens. We believe your hard work should be recognized. We also understand that without your hard work and dedication we would not be the district we are today.

As many of you may be aware, the cost of health insurance has continued to increase for both the employee and the employers. With that said, Fitzgerald Public Schools is happy to announce that we are offering an insurance plan at a lower premium to ensure that all our employees and their dependents can remain covered without added financial burden.

Employees will be able to choose from the following benefit plans for the 2021-2022 plan year.

- Blue Care Network (HMO) – Medical Insurance
- BCBS Blue Dental PPO – Coordination and Non-Coordination
- BCBS VSP 2 Vision
- Reliance Standard Life, Accidental Death and Dismemberment Insurance and Long Term Disability

More information about each of these plans can be found in this booklet.

Open enrollment is an important time of year because it is the only time that you can elect or make changes to your benefits unless you have a qualifying event.

Open Enrollment Dates: November 1 – 30, 2021 Effective Date of Coverage: January 1, 2022

As you read through the following pages of this booklet, please let me know if you have any questions by calling 586-757-1751 or emailing crikoe@myfitz.net.

Sincerely,

Cristal Koehn-Socia
Human Resource Specialist

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Helpful Contacts

Benefit	Company/Contact	Phone Number	Website/Email
Medical/RX Plan	Blue Care Network	800-662-6667	bcbsm.com
Dental Plan	BCBSM - Blue Dental PPO	800-662-6667	bcbsm.com
Vision Plan	BCBS - VSP 2	800-662-6667	bcbsm.com
Life, AD&D, LTD	Reliance Standard / Cristal Koehn-Socia	586-757-1751	crikoe@myfitz.net
Health Savings Account (HSA)	Health Equity	866-346-5800	healthequity.com
Flexible Spending Account (FSA)	Varipro	800-732-3412	varipro.com
General Questions	Cristal Koehn-Socia	586-757-1751	crikoe@myfitz.net

Disclosure: This benefit guide is intended for use only as a source of reference. This document is not a guarantee of benefits.

Eligibility

New Hire Coverage

For newly hired employees, your benefits will begin on the first day of employment. You will have 30 days from your eligibility date to make your benefit selections. Any necessary deductions from your paycheck will be prorated back to your eligibility date. If you do not enroll within the first 30 days of your eligibility date, you will not be eligible for coverage until the next open enrollment period unless you have a qualifying life event.

Terminating Coverage

If you leave Fitzgerald Public Schools for any reason during the school year your benefit premium shall be paid up to but not beyond the end of the month of termination (reference union contract for more information). In the event that you are eligible for COBRA coverage you will receive a packet with all documentation. If you would like to elect COBRA or have any questions, please contact Cristal Koehn-Socia at 586-757-1751 or by email at crikoe@myfitz.net

Eligible Dependents

Legal Spouse

If you are eligible for coverage, your spouse by marriage as defined by law, is also eligible.

Child(ren) over age 18

A dependent adult child aged 19 – 25 is eligible for medical, dental, and vision coverage until the end of the calendar year in which they turn 25.

- You must provide the majority of the child's financial support.
- The child cannot be married.

Under the Affordable Care Act, adult children 19-26 are eligible to continue only medical coverage until the end of the calendar year in which they turn 26.

- The child does not need to be dependent on you for support.
- The child can be married.
- The child does not need to be a full-time student.
- The child does not have to live with you.

A dependent adult child aged 25 or older is eligible to continue medical, dental and vision coverage beyond the end of the calendar year in which they turn 25 and continuously thereafter if they meet certain criteria.

- The child must be a full-time student (carrying 12 undergraduate credits or 6 graduate credits) or have a severe physical or intellectual impairment* which makes them incapable of self-sustaining employment.
- You must provide the majority of the child's financial support.
- The child must be unmarried.

**Mental illness is not considered a cause of incapacity and therefore is not a basis for continued coverage.*

Dependent Children

When you are eligible for coverage, the following dependent children are also eligible:

- Your natural children
- Stepchildren for whom your spouse has legal custody
- Legally adopted children or children placed with you in anticipation of adoption
- Foster children
- Children for whom you have court-appointed guardianship
- Children for whom you must provide coverage as described by a Qualified Medical Child Support Order (QMSCO)

Disabled Children

Disabled children are eligible for coverage over the age of 26, provided they are unmarried; primarily dependent on you for support because of mental or physical handicap; and for whom you give BCN satisfactory proof of such mental or physical handicap within 31 days after the later of the commencement of such mental or physical handicap or the date your first become an eligible employee under this plan.

If you are adding a new dependent to your benefits, you will be required to provide proof of relationship. For your dependent(s) coverage to be active you will need to provide the required documentation.

Examples:

Proof of Marital Status: Copy of Marriage Certificate

Proof of Dependent: Copy of Birth Certificate

**No person may be covered as both an employee and a dependent, and no person may be covered as a dependent of more than one employee.*

Elections

It is important that you make your choices carefully since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for certain changes in status during the year, allowing you to make a mid-year benefit change consistent with the change in status. If you have a change in status, you must change your benefit elections within 30 days of the qualifying event. Failure to do so will forfeit your enrollment period.

A status of change includes:

- Change in legal marital status (marriage, death of spouse, divorce, or legal separation).
- Change in the number of dependents (birth, death of dependent, adoption or placement for adoption).
- Change in the employment status of the employee or the employee's spouse including start or end employment, change in eligibility (full time to part time), a strike or lockout, commencement or return from an unpaid leave of absence and a change in worksite.
- Dependent stratifies or ceases to satisfy eligibility requirements (attain particular age).
- Alternate open enrollment timeframe for spouse or loss of other coverage.
- The issuance of a Qualified Medical Child Support Order.

What happens if I do not enroll?

If you do not enroll within the required time period, you will not be eligible to receive any offered voluntary benefits until the next annual open enrollment period, or qualifying event. You may be subject to waiting periods or reduced benefits if you decide to enroll at a later date.

When can I change my benefits?

Your health and welfare benefits remain in effect throughout the 2021-2022 plan year. Generally, you cannot change your benefits, add, or drop out of a plan until the next annual open enrollment. However, if there is a qualifying change in your family status, you will be eligible to change your coverage within 30 days of the qualifying event. Proper documentation must also be provided within the 30 days' time period.

COBRA Continuation Coverage:

When you or any of your dependents no longer meet the eligibility requirements for your employer's health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. In the event of divorce, legal separation or change in dependent status, it is your responsibility to notify Human Resources within 60 days for complete COBRA detail requirements. If you would like to elect COBRA or have any questions, please contact Cristal Koehn-Socia at 586.757.1751 or email crikoe@myfitz.net.

Definitions for Benefit Terms

It is important to be familiar with benefit terms to better understand your options. Take a moment to review these definitions, which may be referenced throughout this guide.

Carrier – Company that holds your insurance policy.

Example: Our health insurance carrier is Blue Care Network (BCN).

Deductible – The amount you pay out of pocket for eligible hospitalizations, outpatient surgery procedures and diagnostic testing.

Example: If your plans deductible is $2,000, you will pay the first $2,000 of covered services yourself. Once you have paid your deductible, you and your insurance carrier will then share any future costs for the plan year. You will be responsible for the copayment and coinsurance, with the carrier covering the remainder of the cost.

Coinsurance – Percentage of costs of a covered health care service you pay after you have paid your deductible. Coinsurance can come in different percentages. Coinsurance for BCN is 50% for select services.

Example: Your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%. If you have paid your deductible: You pay 20% of $100 or $20. The insurance company pays the rest. If you haven't met your deductible: You pay the full allowed amount, $100.

Coinsurance Maximum – Total amount of coinsurance that a member is required to pay before the carrier begins to pay 100% of eligible hospitalizations, outpatient surgery procedures and diagnostic testing.

Example: If you elect BCN, your deductible would be $1,350 and your out-of-pocket maximum is $2,350. You would first be responsible for your $1,350 deductible. Then, you could have coinsurance of 50%-100% while the carrier pays the rest. You will continue to pay the difference until you have paid $3,700 for covered services (out of pocket maximum). Once you have paid the out-of-pocket maximum of $3,700, the carrier will pay 100% of covered health care costs for the remainder of the calendar year.

Premium – The amount that is deducted from your paycheck for your healthcare benefit deductions.

Example: The amount that is deducted from each paycheck.

Copayment – A fixed amount you pay out of pocket for a covered healthcare service to the provider of service. Copayments do not apply to the deductible or coinsurance.

Example: If you visit your Primary Care Physician you will be responsible for $25 at the time of service. This is a predetermined amount by the health insurance plan.

In-Network – Doctors, clinics, hospitals, and other providers that have a contract with the health insurance company and negotiated rates. Members will save money using in-network provider verses using an out-of-network provider.

Out-Of-Network - Doctors, clinics, hospitals, and other providers that do not have a contract with the health insurance company. Members will pay more for using an out-of-network provider than if they use an in-network provider.

2021-2022 Medical Plan Options

Deductible Year: January 1, 2022 - December 31, 2022

Plan A: Blue Care Network HMO

Blue Care Network (HMO)	
00142134/0002/0002 Fitzgerald Public Schools	
Deductible	$1,400 individual / $2,800 family (Combined for both medical and drug coverage) *Family deductible must be met under two (2) person coverage or family coverage before benefits are paid for any person under the contract.
Copays	None
Coinsurance	50% for selected benefits listed below
Out of Pocket Maximum	$2,350 individual / $4,700 family *Applies to deductibles, copays, and coinsurance amounts for all covered services - including prescription drug copays
Preventative Services	
Health Maintenance Exam	100% Covered
Annual Gynecological Exam	100% Covered
Pap Smear Screening	100% Covered
Well-Baby and Child Exam	100% Covered
Immunizations	100% Covered
Prostate Specific Antigen (PSA) Screening	100% Covered
Routine Colonoscopy	100% Covered
Mammography Screening	100% Covered
Voluntary Female Sterilization	100% Covered
Breast Pumps (DME guidelines apply)	100% Covered
Maternity Prenatal Care	100% Covered

Physician Office Services * Deductible does not apply to preventative services and routine maternity care.	
Primary Care Physician (PCP) Office Visits	100% after deductible*
Online Visits	100% after deductible*
Consulting Specialist Care	100% after deductible*
Emergency Medical Care	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Ambulance Services	100% after deductible
Diagnostic Services	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging	100% after deductible
Radiation Therapy	100% after deductible
Maternity Services Provided by a Physician	
Postnatal and Non-routine Prenatal Care	100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	100% after deductible
Hospital Care	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible
Alternatives to Hospital Care	
Skilled Nursing Care	100% after deductible; Up to 45 days per year
Hospice Care	100% after deductible
Home Health Care	100% after deductible
Surgical Services	
Surgery - Includes all related surgical services and anesthesia	100% after deductible
Voluntary Sterilization	Male - 50% after deductible

Elective Abortion (one procedure per two-year preiod of membership)	Not Covered
Human Organ Transplant	100% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures	50% after deductible
Mental Health Care and Substance Use Disorder Treatment	
Inpatient Mental Health Care	100% after deductible
Inpatient Substance Use Disorder	100% after deductible
Outpatient Mental Health Care	100% after deductible
Outpatient Substance Use Disorder	100% after deductible
Autism Spectrum Disorders, Diagnosis and Treatment	
Applied Behavioral Analysis (ABA) Treatment	100% after deductible
Outpatient Physical, Speech and Occupational Therapy for Autism Spectrum Disorder through age 18. Unlimited visits for PT/OT/ST with Autism Spectrum Disorder diagnosis	100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventative benefit.
Other Services	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible; Up to 30 visits per year
Outpatient Physical, Speech and Occupational Therapy	100% after deductible
Infertility Counseling and Treatment (Excludes in-vitro fertilization)	50% after deductible
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% deductible

Prescription Drugs	Tier 1A: $10 after deductible, Tier 1B: $30 after deductible, Tier 2: $60 after deductible, Tier 3: $80 after deductible, Tier 4: 20% coinsurance after deductible (max $200), Tier 5: 20% coinsurance after deductible (max $300),30-day supply; Sexual Dysfunctional Drugs - 50% coinsurance after deductible; Contraceptives: Tier 1A 100% (deductible does not apply), Tier 1B: $30 after deductible, Tier 2: $60 after deductible, Tier 3: $80 after deductible; 30-day supply
Mail Order Prescriptions	30-day supply or less - applicable tiered copay/coinsurance, 31-90-day supply 3x's the 30 day copay/coinsurance minus $10 after deductible
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Hearing Aid	Not Covered

~ This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For more information contact Blue Care Network.

Plan B: Waive Medical Coverage (Cash In Lieu)

Full-time employees (more than 7 hours per day) not electing medical insurance benefits will be provided Three Hundred Eighty Dollars ($380.00) cash payment per month added to gross pay.

Part-time employees are not eligible for cash in lieu.

2021-2022 Medical Contributions

12 Month Full Year Medical Coverage Contributions

July 1, 2021 through June 30, 2022: Employees who are continuing their full year medical coverage from the previous school year.

Full Time (7+ hrs) Per Day	Amount Per Pay:		
	Single	**2 Person**	**Family**
Administrator/Professional Staff (22 Pays) **Pay Dates: Sept. 3, 2021 - Jun. 24, 2022**	$2.62	$106.28	$76.04

6 Month Partial Year Medical Coverage Contributions

January 1, 2022 through June 30, 2022: Employees who are newly enrolling into medical coverage.

Full Time (7+ Hours) Per Day	Amount Per Pay:		
	Single	**2 Person**	**Family**
Administrator/Professional Staff (13 Pays) **Pay Dates: Jan. 7, 2022 - Jun. 24, 2022**	$2.22	$89.93	$64.34

~ Contributions amounts listed above are for newly enrolled employees only. If you are making a change to your plan during open enrollment or during a special enrollment period, you will receive an email from Cristal Koehn-Socia, HR Specialist, with your new per pay contribution amount.

Understanding Blue Care Network's Referral Process

Your doctor is your health partner

Your primary care physician, or PCP, is responsible for the care you receive – from preventative health services to treatment for illness. As your healthcare partner, your PCP makes sure that you get the care you need when you need it.

Getting care

PCP's can provide many services in their offices. Your PCP also arranges for specialist care or special tests. Your network gynecologist or obstetrician can also refer you to specialists for OB/GYN-related services. Your specialist will decide on the services and the number of visits required for treatment.

Extensive network of specialists

Our network includes thousands of specialists. More than likely, your PCP will refer you to someone he or she knows professionally. Sometimes the specialist may even be part of the same group as your PCP.

When you don't need a referral

You don't need a referral for behavioral health, but you must be seen by a network provider. Also, female members don't need a referral to see a network gynecologist or obstetrician for annual well woman visits and obstetrical care (Woman's Choice program). Your network OB/GYN can also refer you for specialist care, but only for OB/GYN-related services.

Chiropractic services

Your PCP must send a global referral to the chiropractor who will provide your care. The chiropractor must then contact BCN for approval before providing manipulation or physical medicine services.

Referrals for specialist care

Your PCP manages your health care through a referral process with these guidelines:

- Your PCP refers you to a specialist. Check that the specialist is in your plan's network. Also ask if there's anything else you need to do to ensure coverage.
- You may need special approval from BCN for certain services and for services from specialists who aren't in your plan's network.
- Only your PCP or OB-GYN can refer you for specialist care.
- If the service requires a referral and your PCP or OB-GYN doesn't refer you, you're responsible for the charges.
- Changing your PCP while a specialist is treating you may change your treatment authorization. Check with your new PCP.

Questions?

If you or your PCP have questions about the referral process, please call customer service at the number on the back of your ID card. Representatives are available between 8:00 am and 5:30 pm Monday through Friday.

24/7 Online Health Care

You now can get quality health care, anytime, anywhere*

Life is online 24/7

You're used to the convenience of banking, shopping, and taking care of personal business online when you're pressed with time, or when it's convenient for you. Health care doesn't have to be any different. Why not see a board-certified doctor online too?

No appointment needed

You can get fast, convenient, affordable online health care 24 hours a day, seven days a week, wherever you are in the U.S.* Just choose an available doctor, click, and go. It's as simple as using your mobile device or computer to meet with a doctor face-to-face, online, when:

- Your primary doctor isn't available
- You can't leave your home or workplace
- You're on vacation or traveling for work
- You're caring for children or a family member and can't leave home
- You're looking for affordable after-hours care

It's for the whole family

Family members on your plan can also use 24/7 online health care. Just add children younger than age 18 to your account. Your spouse, and children aged 18 and over, should create their own accounts.

When should I use an online doctor?

You can use Amwell™, American Well's award-winning and easy-to-use online health care technology, for minor illnesses, such as:

- Sinus and respiratory infections
- Colds, flu, and seasonal allergies
- Minor burns, cuts, and scrapes
- Skin rash
- Painful urination
- Eye irritation or redness
- Sore throat
- Earache
- Vomiting

2021-2022 Dental Plans – BCBS Blue Dental PPO

There are two options for dental coverage provided to employees, Coordination of Benefits and Non-Coordination of Benefits. An employee will select Coordination of Benefits for dental plans if they have other dental coverage outside of the district plan. For example, the employee could also be covered by a spouse, parent (if under 27 years of age), Medicare or State plan, etc. An employee would select Non-Coordination of Benefits for dental if they do not have other coverage outside of the district plan.

Network Access Information:
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network:
Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.

Note: Members who go to non participating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility Information:

- Subscriber; employed by Fitzgerald Public Schools
- Subscriber's legal spouse
- Dependent children: related to you by birth, marriage, legal adoption, or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn 26, provided all eligibility requirements are met.

Benefits	Coordination of Benefits	Non-Coordination of Benefits
Deductible	None	None
Coinsurance (percentage of BCBSMs approved amount for covered services)		
Class I Services	50%	20%
Class II Services	50%	20%
Class III Services	50%	20%
Class IV Services	50%	20%
Annual Maximum for Class I, II, and III	$1,500 per member	$1,500 per member

Annual Maximum for Class IV	$2,000 per member	$2,000 per member
Class I Services	**Coordination of Benefits**	**Non-Coordination of Benefits**
Oral Exams	50% of approved amount; 2x per calendar year	80% of approved amount; 2x per calendar year
A set (up to 4 films) of bitewing x-rays	50% of approved amount; 2x per calendar year	80% of approved amount; 2x per calendar year
Panoramic or full-mouth x-rays	50% of approved amount; 2x per calendar year	80% of approved amount; 2x per calendar year
Pit and fissure sealants - members aged 19 and under	50% of approved amount; once per tooth in any 36 consecutive months when applied to the first and second permanent molars	80% of approved amount; once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	50% of approved amount	80% of approved amount
Fluoride treatment	50% of approved amount; 2x per calendar year	80% of approved amount 2x per calendar year
Space maintainers - missing posterior (back) primary teeth - members aged 19 and under	50% of approved amount; once per quadrant per lifetime	80% of approved amount; once per quadrat per lifetime
Class II Services	**Coordination of Benefits**	**Non-Coordination of Benefits**
Fillings - permanent (adult) teeth	50% of approved amount; Replacement fillings covered after 24 months or more after initial filling	80% of approved amount; Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount; Replacement fillings covered after 12 months or more after initial filling	80% of approved amount; Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns, and veneer restorations - permanent teeth - members aged 12 and older	50% of approved amount; once every 60 months per tooth	80% of approved amount; once every 60 months per tooth
Oral surgery, except simply extractions	50% of approved amount	80% of approved amount
Root canal treatment - permanent tooth	50% of approved amount; once every 12 months for tooth with one or more canals	80% of approved amount; once every 12 months for tooth with one or more canals

Scaling and root planning	50% of approved amount; once every 24 months per quadrant	80% of approved amount; once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount; covered up to 5x in any 60 consecutive months	80% of approved amount; covered up to 5x in any 60 consecutive months
Occlusal biteguards	50% of approved amount; once every 12 months	80% of approved amount; once every 12 months
General anesthesia or IV sedation	50% of approved amount; when medically necessary and performed with oral surgery	80% of approved amount; when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount; 6 months or more after denture is delivered	80% of approved amount; 6 months or more after denture is delivered
Relining or rebasing of partial or complete denture	50% of approved amount; Once per arch in any 36 consecutive months	80% of approved amount; Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount; Once per arch in any 36 consecutive months	80% of approved amount; Once per arch in any 36 consecutive months
Class III Services	**Coordination of Benefits**	**Non-Coordination of Benefits**
Removable dentures (complete and partial)	50% of approved amount; Once every 60 months	80% of approved amount; Once every 60 months
Bridges (fixed partial dentures) – for members aged 16 and older	50% of approved amount, once every 60 months after original was delivered	80% of approved amount, once every 60 months after original was delivered
Endosteal implants – for members aged 16 and older who are covered at the time of the actual implant placement	50% of approved amount; Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31	80% of approved amount; Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Class IV Services - Orthodontic services for dependents under age 19	**Coordination of Benefits**	**Non-Coordination of Benefits**
Minor treat. for tooth guidance app.	50% of approved amount	80% of approved amount

Minor treatment to control harmful habits	50% of approved amount	80% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount	80% of approved amount
Post-treatment stabilization	50% of approved amount	80% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount	80% of approved amount

Note: For non-urgent, complex, or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination before treatment begins.

2021-2022 Dental Contributions

Dental insurance is paid for by the Fitzgerald Board of Education for all employees, their spouses and dependents. However, the employee must complete an enrollment form to qualify for this benefit. The employee is responsible for any out of pocket costs incurred.

2021-2022 Vision Plan – Vision Service Plan (VSP)

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP website at vsp.com.

Note: Members may choose between prescription glasses (lenses and frames) or contact lenses, but not both.

Member's Responsibility (Co-Pays)			
Benefits	**Coordination of Benefits (Combined with Dental) In-Network**	**Non-Coord. Benefits (Combined with Dental) In-Network**	**Vision Only (No Dental) In-Network**
Eye Exam	None	$5.00 Copay	$5.00 Copay
Prescription Glasses (Lenses/Frames)	None	Combined $7.50 Copay	Combined $7.50 CoPay
Medically Necessary Contact Lenses	Non	$7.50 Copay	$7.50
Eye Exam One exam in any 12 consecutive months			
Eye Exam (Includes refraction, glaucoma testing and other necessary tests to determine overall visual health of the patient)	100% of approved amount	$5.00 Copay	$5.00 Copay
Lenses and Frames One frame and one set of lenses in any 12 consecutive months			
Standard lenses (must not exceed 60mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	$7.50 Copay (one copay applies to both lenses and frames)	$7.50 Copay (one copay applies to both lenses and frames)

Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to both lenses and frames)	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to both lenses and frames)
Contact Lenses **Contact lenses up to the allowance in any 12 consecutive months**			
Medically necessary contact lenses (require prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	$7.50 Copay	$7.50 Copay
Elective contact lenses that improve vision (prescribed, but do not meet criteria for medically necessary)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

2021-2022 Vision Contributions

Vision insurance is paid for by the Fitzgerald Board of Education for all employees, their spouses and dependents. However, the employee must complete an enrollment form to qualify for this benefit. The employee is responsible for any out of pocket costs incurred.

Reliance Standard Life, Accidental Death & Dismemberment (AD&D) and Long-term Disability (LTD) Insurance

Life, AD&D and LTD insurance is paid for by the Fitzgerald Board of Education for all employees. However, the employee must complete an enrollment form to qualify for this benefit.

Life and AD&D Insurance:

- Full-time employees electing medical coverage:
  - Term Life Insurance in the amount of $45,000 for the employee only. Such insurance protection shall be paid to the employee's designated beneficiary. In the event of accidental death, the insurance will pay double the specified amount; in the event of accidental dismemberment, the insurance will pay according to the schedule.
- Full-time employees not electing medical coverage:
  - Term Life Insurance in the amount of $50,000 for the employee only. Such insurance protection shall be paid to the employee's designated beneficiary. In the event of accidental death, the insurance will pay double the specified amount; in the event of accidental dismemberment, the insurance will pay according to the schedule.
  - Dependent Term Life Insurance in the amount of $10,000 for each employee's spouse and $5,000 for each dependent child.
- Part-time employees 6-7 hours per day:
  - Term Life Insurance in the amount of $10,000 for the employee only. Such insurance protection shall be paid to the employee's designated beneficiary. In the event of accidental death, the insurance will pay double the specified amount; in the event of accidental dismemberment, the insurance will pay according to the schedule.

Long Term Disability:

Benefits shall be paid at 66 2/3% of the salary to a maximum monthly benefit of $5,000 and may begin after expiration of 90 calendar days. Benefits shall be to age 65 for disabilities that occur prior to age 61; for disabilities that occur on or after age 61, benefits end 5 years after the disability or age 70, whichever occurs first; after age 70, coverage is for 1 year; at no cost to the employees in the event of permanent disability.

Health Savings Account - Health Equity

Fitzgerald Public Schools allows employees enrolled in a HSA-qualified health plan to participate in a Health Savings Account offered through Health Equity. BCN is a HSA-qualified health plan.

How an HSA Works

- An HSA paired with an HSA-qualified health plan allows you to make tax-free contributions to a federally insured savings account.
- HSA-qualified health plans typically cost less than traditional plans and the money saved can be put into your HSA.
- HSA balances earn tax-free interest and can be used to pay for qualified medical expenses.

Who is eligible for an HSA?

- You are covered by an HSA-qualified health plan and have no other health coverage, such as health plan, Medicare, military health benefits, medical FSAs.
- You cannot be claimed as a dependent on another person's tax return.
- Need to transfer your HAS? Visit healthequity.com for a Transfer Request Form.

Maximize your savings

To take full advantage of tax savings and to build a reserve for the future, it is suggested that you maximize your contributions as set by the IRS:

Tax Year	HSA Contribution Limits	
	Individual	**2 Person / Family**
2022	$3,650	$7,300
At age 55, an additional $1,000 is allowed annually		

Discover the many uses for your HSA

Qualified medical expenses (QMEs) are designated by the IRS and include medical, dental, vision and prescription expenses. A complete list is available at https://healthequity.com/learn/qualified-medical-expenses

What if…

I do not have enough money in my HAS to pay a medical expense.

- If you need to pay a medical bill but do not have a sufficient balance to cover the expense, you have the following options:
- Many healthcare providers will allow you to pay installments over a period of time. You can even set up recurring payments on the member portal once you have authorized installment payments with your provider.
- You can pay for medical expenses out-of-pocket and reimburse yourself once your balance is sufficient.

- As long as a medical expense is incurred after your HSA is established, you can use your HSA funds to cover that expense.

I leave my employer.

- You own the HSA, so even if you leave your employer, the account stays with you. In fact, if you keep your HSA-qualified health plan or enroll in another HSA-qualified health plan, you can still contribute to your Health Equity HSA.

I change my health plan.

- If your new health plan is not compatible with an HSA, you will not be able to continue making contributions to your HSA. However, any funds you have contributed can continue to be accessed tax-free to pay for the qualified medical expenses of you and your tax dependents.
- You can also contribute additional funds to the account if you have not made the maximum eligible contribution based on how long you were covered, however leaving the plan early may result in excess contributions to your account.

I die.

- Establishing a beneficiary for your account will save your loved ones a lot of difficulty in the event of your death. It is one of the first actions we recommend completing when you open your HSA.
- A spouse beneficiary can assume ownership of the account without tax penalties or receive a taxable lump sum distribution. All other beneficiaries would receive a taxable lump sum. Taxes are assessed on the value of the account on the date of death.

For more information call member services at 866-346-5800 or go online to healthequity.com

Be Smart About Your Flexible Spending Account Plan

Flexible Spending Accounts (FSA) are a great way to increase your take-home pay and save taxes on money you spend for medical and dependent care expenses.

That's because you do not pay income tax or Social Security tax on your election amount (the money you set aside). A Health FSA account is used for medical expenses, and a Dependent Care Assistance Plan (DCAP) account is used for child care expenses.

Health FSA

In a Health FSA account, you can put aside funds to pay for unreimbursed medical, dental and vision expenses (that is, bills that are not paid by any insurance) for yourself and qualifying dependents.

You have access to the full amount of your Annual Election beginning on the first day of the Plan Year.

A list of qualified and non-qualified medical expenses, is included within this informational packet.

Dependent Care Assistance Plan

The Internal Revenue Service (IRS) permits you to exclude from gross income a certain amount of the dependent care expenses that you pay in order to work or look for work and provides two methods for you to do this. Under IRC §21, you can deduct qualified expenses as a Dependent Care Tax Credit when filing your annual income tax return. Alternatively, IRC §129 allows you to participate in a Dependent Care Assistance Plan (DCAP) through your employer's cafeteria plan. The maximum that can be set aside under this plan is set by the IRS at $5,000 per year per family. DCAP applies to children from birth until their 13th birthday and can reimburse for daycare, preschool and pre-kindergarten, before- and afterschool care, and summer camp (day camp only).

Participation may not be continued while on a leave of absence or layoff. If you return to work during the same Plan Year, your contributions will restart at the same contribution rate in place before you left, unless you request a change due to a qualifying event.

IRS rules state you cannot claim the same expenses under both the dependent care account and the federal tax credit. As a result, you will have to decide which one is more advantageous to you.

You do *not* have full access to your Annual Election beginning with the new Plan Year. You may only withdraw the amount contributed up to the time you file a claim.

FITZGERALD PUBLIC SCHOOLS

Benefits: Health Care & Dependent Care Reimbursement

Plan Year: January 1, 2022–December 31, 2022

Maximum Health Care Contribution per Plan Year: $2,750

Minimum Health Care Contribution per Plan Year: None

Maximum Dependent Care Contribution per Taxable Year (i.e., calendar year): $5,000

Number of Pay Periods: 22

Debit Card Available: Yes

Runout Period: 60 days after the plan year ends to submit claims

Runout Period After Termination: You have 60 days after date of termination to file claims incurred before your termination date

Carry-Over Provision: You are allowed to carry-over up to $550 in unused account balance dollars to the following plan year.

Check Runs: Checks are mailed directly to you three times a week. If you elect direct deposit, the funds will be deposited the next business day.

Use it or Lose it: Carry-Over Provision

The IRS permits employers to allow participants to carry, or roll over, up to $550 in unused funds from the prior Plan Year into the new Plan Year.

Estimate your expenses carefully, as any amount in the Health Care FSA above the Plan's Carry-Over limit is forfeited.

The Carry-Over provision does not apply to Dependent Care Assistance Plans.

Can I Change My Coverage During the Year?

The benefit choices that you are making now will remain in effect until the last day of the plan year, unless you experience a qualified change in family status. If you have a qualified change in family status, the IRS allows you to change your coverage during the plan year to meet your changing needs.

Qualified family status changes include:

- Change in Legal Marital Status - your marriage, divorce, or legal separation
- Change in Dependents - the birth, death, or adoption of a child
- Change in Employment - termination, retirement, change in hours with you or spouse, layoff
- Change in Residence or Worksite – of employee or spouse
- Change in Dependent Status – dependent starts or stops meeting requirements to be eligible for any coverage under this plan

Change in Dependent Care Only:

- Change in Cost – change in cost to provide dependent care
- Change in Coverage – addition or elimination of benefits options
- Change Under Another Plan - change in dependent care benefits under another employer's plan

If you experience such a change and would like to change your coverage, you must notify your Human Resource Department within 30 days of the qualified change in family status.

Any change you make must be consistent with your change in family status. For example, if you have a baby during the year, you may be eligible to change your Health Care election or you can choose to begin participating in the dependent care reimbursement account, but you could not decide to stop participating in the health care reimbursement account.

What information can I find on your website?

The website and mobile app offer 24/7 access to your account balance, claims history and the ability to file claims online.

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims history and payment (reimbursement) history
- Report a lost/stolen Card and request a new one
- Update your personal profile information
- Change your login ID and/or password
- Download plan information, forms and notifications

Tax Savings Calculator

Below is an example of the savings a typical FSA participant experiences by contributing to a Health FSA and a Dependent Care Assistance Plan. Varipro offers an automated calculator the through member.varipro.com website.

Example participant is a Michigan resident who is married and files a joint federal tax return.

Without a Section 125 Cafeteria Plan

Gross Taxable Income	$40,000
Federal Income Tax	$ 6,000
Social Security/Medicare Taxes	$ 3,060
State Income Tax	$ 1,700
Spendable Income	$29,240
Less Dependent Day Care Expense	$ 5,000
Less Out-of-Pocket Medical/Dental/Vision	$ 2,000
Net Take-Home Pay	$22,240

With a Section 125 Cafeteria Plan

Gross Taxable Income	$40,000
Less Dependent Day Care Expense	$ 5,000
Less Out-of-Pocket Medical/Dental/Vision	$ 2,000
Taxable Income	$33,000
Federal Income Tax	$ 4,950
Social Security/Medicare Taxes	$ 2,524
State Income Tax.	$ 1,402
Net Take-Home Pay	$24,124

This example is designed to provide estimations in regard to the subject matter covered. It is furnished with the understanding that Varipro is not engaged in rendering legal or accounting advice. If legal advice or tax services are required, contact your attorney or tax professional

Increase in Spendable Income Through Section 125 Plan:
$1,884 annually,
or $36.23 per week

FSA Worksheet

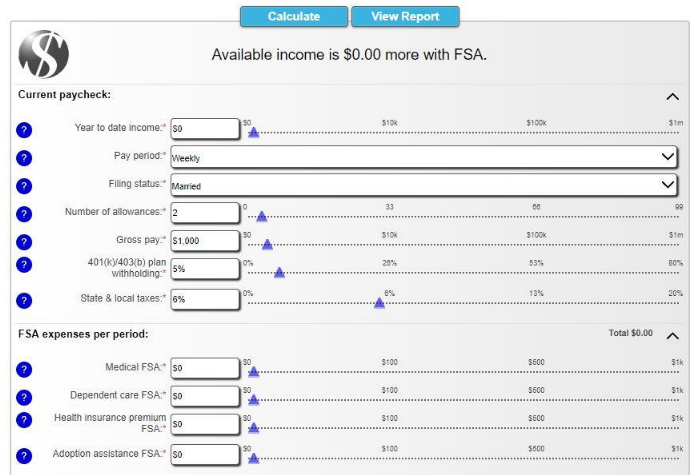
Use this worksheet to estimate the amount you want to set aside in your flexible spending accounts

Health Care Expenses

Insurance Deductibles	$ ______
Insurance Co-Pays	$ ______
Dental Deductibles	$ ______
Dental Expenses	$ ______
Vision Expenses	$ ______
Hearing Expenses	$ ______
Prescriptions	$ ______
Medical Equipment	$ ______
Chiropractor	$ ______
Other Medical Expenses	$ ______
Total Out-of-Pocket Health Care Expenses	$ ______
Divide by Number of Pay Periods Per Year	÷ ______
= Per-Payroll Deduction for Health FSA	$ ______

Dependent Care for Eligible Dependents

Day Care Cost Per Week	$ ______
Multiply by 52 weeks	$ ______
Total Annual Cost (Maximum $5,000)	$ ______
Divide by Number of Pay Periods Per Year	÷ ______
= Per-Payroll Deduction for DCAP	$ ______



Flexible Spending Account Frequently Asked Questions

Q: What if I am not covered or I do not have my dependents covered under my company's health insurance plan?

A: You and your family can still participate in the Health Flexible Spending Account (FSA) or Dependent Care Assistance Plan (DCAP) Reimbursement Account.

Q: Why should I participate in the health flexible spending account when I already have health insurance?

A: This account is used to pay for expenses that are not covered by insurance. For example, your insurance may not cover annual physicals, co-payments, eye exams, glasses, contacts, orthodontics, prescription drugs, or dental care, just to name a few. (See Eligible/Non-Eligible Expenses list.)

Q: What if I have a claim early in the plan year and do not have enough money in my account?

A: You are eligible for 100% of your election at the start of the plan year for your Health FSA. This is referred to as the "Uniform Coverage Rule." It gives you the ability to budget your medical expenses and spread them out over the entire year. Your elected payroll deductions will continue throughout the plan year to catch up on the expenses you have been advanced. For the DCAP account, you will be reimbursed as your deductions are deposited with your employer.

Q: Do I have to have a lot of expenses to participate?

A: No. You may put aside enough money to cover what you reasonably expect to spend during your plan year. You should not put more than that, because if you do not use the money, you will lose it. The Internal Revenue Service mandates this provision of the law.

Q: How do I figure how much to put into my medical expense account?

A: Look at your receipts or check register for the last year or two to see what you typically spend annually on medical expenses for yourself and qualified family members. Or, think about what you expect to spend on medical expenses during your plan year. You may be provided with a worksheet to use in estimating your expenses.

Q: Are "Over the Counter" drugs eligible for reimbursement?

A: According to the CARES ACT, passed March 27, 2020, in response to the COVID 19 pandemic, many "over the counter" drugs including menstrual products are now reimbursable under your FSA for items obtained January 1, 2020 or after.

Q: What is proof of payment/required documentation?

A: This would be a copy of your statement, invoice, visit record, explanation of benefits (EOB), or similar document. It should show the date, type of service, the amount of payment, and the provider. Voided/canceled checks and Balance Forward statements are not qualified receipts.

Q: If I set aside pre-tax money in a spending account, why would I lose the money If I don't spend it?

A: In exchange for the substantial tax advantages associated with an FSA, the IRS requires that any money left in the FSA at the end of the plan year, will be forfeited. This is known as the "use it or lose it" rule. However, if you plan properly, you most likely will not forfeit any money. There are many ways to spend any unused balance before the end of the plan year.

Q: Can expenses be reimbursed from my DCAP at the beginning of the month for care that will be provided during that month?

A: No, regulations require that claims can only be reimbursed after a service has been incurred. So, even though a participant pays for dependent care at the beginning of the month, until the care has been provided, the participant is not entitled to the reimbursement.

Q: Can I participate in the Dependent Care Assistance Plan and also claim the dependent care tax credit?

A: There is no 'double-dipping.' If you are using a DCAP you may not also elect the tax credit on the same money. Please consult with your accountant or flex administrator for further review.

Q: Can I change my coverage or contributions during the plan year?

A: The benefit choices that you make will remain in effect until the last day of the plan year, unless you experience a qualified change in family status. If you have a qualifying event or change in status such as marriage, divorce, birth or placement for adoption or loss of a covered dependent, you can change your election amount.

In addition to those mentioned, you are also allowed to make a change to your Dependent Care contribution amount if there is a change in cost to provide dependent care, if there is a change in coverage or change in dependent care benefits under another employee plan.

Q: Can I transfer an account balance from one account to another?

A: No. There is no transfer feature permitted.

Q: What happens if I leave my job?

A: Once your employment is terminated, your plan year is over. The only expenses that you can submit are those that you incurred from the entry date through the date of termination. These claims need to be submitted within the "run out" period specific to your plan.

You may be eligible for COBRA continuation of coverage. Check with your employer for more information.

Q: What is the "run out" period?

A: It is a specified period of time after the end of the plan year, or after an employment termination date, in which you may submit claims incurred during the time you were covered. For example, if your plan has a 60-day run out period, you will have 60 days from the end of the plan year or 60 days from your termination date to submit claims incurred before your termination date.

Q: How do I submit my claim for reimbursement?

A: You can send your claim to Varipro by using one of the options below:

Upload claims online:
www.member.varipro.com

Snap a picture using the mobile app

Via Fax: 844-902-4564

Via Email: Flex@varipro.com

US Mail: Varipro
Attn: Flexible Spending
5300 Patterson SE, Suite 150
Grand Rapids, Michigan 49512

Q: How do I know how much money is in my account?

A: You can check your account balance 24 hours a day, seven days a week online or in the mobile app. You will also receive your remaining account balance with each reimbursement check.

FSA Eligible & Non-Eligible Expenses

FSA/HSA Eligible Health Care Expenses

Please note that we do not intend this list to be comprehensive tax advice.
For more detailed information, consult IRS Publication 502 or see your tax advisor.

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground/air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped*
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Deaf services-- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental treatment
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription)
- Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices*
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment)
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy related physicals)
- Schools (special, relief, or handicapped)
- Sexual dysfunction treatment
- Smoking cessation programs
- Surgical fees
- Television or telephone for the hearing impaired
- Therapy treatments*
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Vitamins*
- Weight-loss programs*
- X-rays

FSA/HSA Eligible OTC Medications and Products

For a complete list, or to purchase eligible products on line check out Amazon's Health Shopper or the FSA Store. You can access these links from the member portal or through www.varipro.com.

- Acne medications & treatments
- Allergy & sinus, cold, flu & cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Antacids & acid controllers (tablets, liquids, capsules)
- Antibiotic & antiseptic sprays, creams & ointments
- Anti-diarrheas
- Anti-fungals
- Anti-gas & stomach remedies
- Anti-itch & insect bite remedies
- Anti-parasitics
- Baby care (diaper rash ointments, teething gel, rehydration fluids, etc.)
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Digestive aids
- Eczema & psoriasis remedies
- Eye drops, ear drops, nasal sprays
- First aid kits
- Hemorrhoidal preparations
- Hydrogen peroxide, rubbing alcohol
- Laxatives
- Menstrual Products
- Medicated band-aids & dressings
- Motion sickness remedies
- Nicotine patches and medications (smoking cessation aids)
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Sleep aids & sedatives
- Wart removal remedies, corn patches

EXAMPLES OF ITEMS ELIGIBLE FOR REIMBURSEMENT WITH DETAILED RECEIPT ONLY (NO PRESCRIPTION REQUIRED):

- Braces & supports
- Breast pumps for nursing mothers
- Contact lens solution
- CPAP equipment & supplies
- Diabetic testing supplies /equipment
- Durable medical equipment (power chairs, walkers, wheelchairs, etc.)
- Home diagnostic (pregnancy tests, ovulation kits,
- Non-medicated band-aids, rolled bandages & dressings
- OTC varieties of Insulin
- Reading glasses
- Sunscreen
- Thermometers, blood pressure monitors, etc.)

FSA Non-Eligible Health Care Expenses

Advance payment for services to be rendered

Automobile insurance premium allocable to medical coverage

Boarding school fees

Body piercing

Bottled water

Chauffeur services

Controlled substances

Cosmetic surgery and procedures

Cosmetic dental procedures

Dancing lessons

Diapers for Infants

Diaper service

Ear piercing

Electrolysis

Fees written off by provider

Food supplements

Funeral, cremation, or burial expenses

Hair transplant

Herbs & herbal supplements

Household & domestic help

Health programs, health clubs, and gyms

Illegal operations and treatments

Illegally procured drugs

Insurance premiums

Long-term care services

Maternity clothes

Medical savings accounts

Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits

Personal items

Preferred provider discounts

Social activities

Special foods and beverages

Swimming lessons

Tattoos/tattoo removal

Teeth whitening

Transportation expenses to & from work

Travel for general health improvement

Uniforms

Vitamins & supplements without prescription

Employee Assistance Program

Fitzgerald Public Schools is proud to announce a commitment to you and your eligible family members in providing you with resources and guidance for personal challenges that are part of life with an Employee Assistance Program. Our provider is CARE's WorkLife Solutions. Fitzgerald Public Schools committed to employee wellness, and we know that when employees and/or their eligible family members are struggling with personal challenges, this can affect their overall mental, emotional and physical well-being.

CARE's WorkLife Solutions services are available to both you and your eligible family members.
CARE's WorkLife Solutions is staffed with experienced counselors to help with a variety of issues including:

- Counseling for you and your immediate family members
- Childcare, elder care and family support
- Daily stresses
- Health and well –being
- Referrals to providers, specialists, and resources to meet specific work, life or care giving needs
- Website resources and support

Each employee and each eligible family member have free and confidential access to five individual counseling sessions with a master level counselor to provide short-term problem-solving sessions. CARE's WorkLife Solutions has access to over 50,000 master level counselors to support you at a location that is convenient.

The service is free to Fitzgerald Public School employees and their eligible family members 24 hours a day, seven days a week. By calling toll free 866.888.1555, you can consult with a counselor over the phone or arrange to see a counselor that is convenient for you or your eligible family member face-to-face.

What's most important is that your confidentiality is assured under state and federal laws. For employees who call on their own to CARE's WorkLife Solutions, Fitzgerald Public Schools receives no information as to which employees use the service or what they use it for. More information regarding this program will be sent to you within the next couple weeks.

Each of you deserves support when "life happens". At times when problems are too tough to manage alone it's good to know CARE's WorkLife Solutions is there.

To access CARE online visit https://www.careofsem.com/employee-assistance-programs/ click EAP login and enter password Spartan-wls

If you need assistance accessing care please contact Cristal Koehn-Socia, HR Specialist, at 586-757-1751.

Annual Notices

Women's Health & Cancer Rights Act

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

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

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

If you would like more information on WHCRA benefits, call your HR department at 586-757-1751.

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under Fitzgerald Public School's Group Health Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under Fitzgerald Public School's Group Health Plan but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under Fitzgerald Public School's Group Health Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institute (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's Law, please contact your HR department at 586-757-1751.

Children's Health Insurance Reauthorization Act (CHIPRA)

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 HR department at 586-757-1751.

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

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

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

HIPAA Notice of Privacy Practices Reminder

Fitzgerald Public Schools is committed to the privacy of your health information. The administrators of the Fitzgerald Public Schools Group Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the HR department at 586-757-1751.

HIPAA Special Enrollment Rights

Fitzgerald Public Schools Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Fitzgerald Public Schools Group Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA required that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the HR department at 586-757-1751.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn 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 the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Medicare Part D – Prescription Drug Coverage

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

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

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

Fitzgerald Public Schools has determined that the prescription drug coverage offered by MESSA Choices II, Essentials by MESSA and Blue Care Network are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Fitzgerald Public Schools coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Fitzgerald Public School coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Fitzgerald Public Schools and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage:
Contact the Human Resources Department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description located on the District website or contact Cristal Koehn-Socia, Human Resource Specialist at 586-757-1751.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such cost.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. IF you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer Name
Fitzgerald Public Schools</td><td colspan="2">4. Employer Identification Number (EIN)
38-6002566</td></tr>
<tr><td colspan="2">5. Employer Address
23200 Ryan Road</td><td colspan="2">6. Employer Phone Number
586-757-1751</td></tr>
<tr><td>7. City
Warren</td><td colspan="2">8. State
Michigan</td><td>9. ZIP Code
48091</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Cristal Koehn-Socia</td></tr>
<tr><td colspan="2">11. Phone Number
586-757-1751</td><td colspan="2">12.Email Address
crikoe@myfitz.net</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑ All employees. Eligible employees are: All full-time employees

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Dependent children are eligible for coverage through the end of the year in which they turn 26.

  ☐ We do not offer coverage.

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

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