Fitzgerald Public Schools

2022-2023 Benefit Enrollment Guide

Local 2654 Members

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 employer. 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 2022-2023 plan year.

- Blue Care Network (HMO) – Medical Insurance
- Simple Blue PPO - Medical Insurance
- BCBS Blue Dental PPO Insurance – Coordination and Non-Coordination
- BCBS VSP 2 Vision Insurance
- 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, 2022 Effective Date of Coverage: January 1, 2023

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

Helpful Contacts

Benefit	Company/Contact	Phone Number	Website/Email
Medical/RX Plan	Blue Care Network HMO Simply Blue PPO	BCN: 800-662-6667 BCBSM: 877-469-2583	bcbsm.com
Dental Plan	BCBSM - Blue Dental PPO	877-469-2583	bcbsm.com
Vision Plan	BCBSM - VSP 2	877-469-2583	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.

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)

Child(ren) over age 18

Under the Affordable Care Act, adult children up to age 26 are eligible to continue medical, dental and vision 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.

Incapacitated/Disabled children over 26 years of age

Children who became permanently disabled — either mentally or physically — prior to age 26 and:

- Are incapable of self-sustaining employment
- Are disability-certified by a physician, and BCBSM/BCN was notified before the end of the year in which the dependent turns 26 years of age
- For BCN dependents, must reside in a BCN service area
- Are unmarried and dependent on subscriber for main support and care as defined by the U.S. Internal Revenue Code

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 2022-2023 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 $1,500 and your out-of-pocket maximum is $4,000. You would first be responsible for your $1,500 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 $4,000 for covered services (out of pocket maximum). Once you have paid the out-of-pocket maximum of $4,000, 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.

2022-2023 Medical Plan Options

Deductible Year: January 1, 2023 - December 31, 2023

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums			
	Blue Care Network HMO*	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
*Beginning 1/1/2023, the IRS increased the minimum deductible to $1,500 for self-only coverage ($100 increase from 2022) $3,000 for family coverage ($200 increase from 2022).			
Deductible **Note**: deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract. The deductible applies to all services except preventive services.	$1,500 for a one-person contract, $3,000 for a family contract (2 or more members) each calendar year (No 4th quarter carry over)	$1,500 for one member $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of Network deductible amounts also count toward the in-network deductible.
Fixed Dollar Copay **Note**: Copayment amounts apply once the deductible has been met.	None	• $30 copay for office visits and office consultations with a non-specialist and specialist provider • $30 copay for medical online visit • $30 copay for chiropractic and osteopathic manipulative therapy • $150 copay for emergency room visits • $30 copay for each urgent care visit	$150 copay for emergency room visits
Coinsurance **Note**: Coinsurance amounts apply once the deductible has been met.	0% and 50% for select services as noted below	None	None
Out of Pocket Maximum - Total amount paid toward medical and pharmacy services including deductible, copays and coinsurance cost-sharing amounts.	$4,000 for one-person contract, $8,000 for a family contract (2 or more members) each calendar year	$8,150 for one member, $16,300 for the family (when two or more members are covered under your contract) each calendar year	$16,300 for one member $32,600 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-Network cost-sharing amounts also count toward the in-network out-of-pocket maximum

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums Continued			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Lifetime dollar maximum	None	None	None
Preventative Services - as defined by the Affordable Care Act			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Health Maintenance Exam	100% Covered	100% (no deductible or copay/coinsurance), one per member per calendar year Included chest x-ray, EKG, cholesterol screening and other select lab procedures. **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Annual Gynecological Exam	100% Covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap Smear Screening	100% Covered - laboratory services only	100% (no deductible or copay/coinsurance), one per member per calendar year - laboratory and pathology services	Not covered
Voluntary Female Sterilization	100% Covered	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription Contraceptive Devices	Contact BCN for coverage	Includes insertion and removal of an intrauterine device by a licensed physician 100% (no deductible or copay/coinsurance)	Includes insertion and removal of an intrauterine device by a licensed physician 80% after out-of-network deductible
Contraceptive Injections	Contact BCN for coverage	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-Baby and Child Care	100% Covered	100% (no deductible or copay/coinsurance) 8 visits, birth - 12 months 6 visits, 13 months - 35 months 2 visits , 36 months - 47 months 48+ months one per member per calendar year	Not covered

Preventative Services - as defined by the Affordable Care Act Continued			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Immunizations - pediatric and adult	100% Covered	100% (no deductible or copay/coinsurance)	Not covered
Fecal Occult Blood Screening	Contact BCN for coverage	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Contact BCN for coverage	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	100% Covered - laboratory services only	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Mammography Screening	100% Covered	100% (no deductible or copay/coinsurance) **Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance One per member per calendar year	80% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. One per member per calendar year
Routine Colonoscopy	100% Covered	100% (no deductible or copay/coinsurance), for the first billed colonoscopy Routine or medically necessary **Note**: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance One per member per calendar year	80% after out-of-network deductible Routine or medically necessary One per member per calendar year
Breast Pumps	100% Covered	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Maternity Pre-Natal Care	100% Covered	Contact Simply Blue for coverage	Contact Simply Blue for coverage

Physician Office Services			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Office Visits	Must be an approved Primary Care Physician (PCP) Covered - 100% after deductible	Must be medically necessary $30 copay per office visit with a non-specialist or specialist provider **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	80% after out-of-network deductible
Online Visits	Covered - 100% after deductible	Must be medically necessary $30 copay per visit **Note**: online visits by a non-BCBSM selected vendor are not covered.	Must be medically necessary 80% after out-of-network deductible **Note**: online visits by a non-BCBSM selected vendor are not covered.
Office Consultations	Covered - 100% after deductible - when referred	Must be medically necessary $30 copay for each office consultation with a non-specialist or specialist provider **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office consultation copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the consultation.	Must be medically necessary 80% after out-of-network deductible
Outpatient and Home Medical Care Visits	Contact BCN for coverage	Must be medically necessary 100% after in-network deductible	Must be medically necessary 80% after out-of-network deductible

Urgent Care Visits			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Urgent Care Visits	Covered - 100% after deductible	$30 copay for each visit **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	80% after out-of-network deductible
Emergency Medical Care			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Hospital Emergency Room	Covered - 100% after deductible	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)
Ambulance Services - medically necessary	Covered - 100% after deductible	100% after in-network deductible	100% after in-network deductible
Retail Health Clinic	Covered - 100% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Diagnostic Services			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Laboratory and Pathology Services	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible
Diagnostic Tests and X-rays	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible
Radiation Therapy	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible

Maternity Services Provided by a Physician			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Prenatal Care Visits	See Preventive Services section	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal Care.	Covered - 100%	100% after in-network deductible	80% after out-of-network deductible
Maternity Services Provided by a Physician			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Delivery and Nursery Care	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible
Hospital Care			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible Unlimited days	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Outpatient Surgery	Contact BCN for specific surgical coinsurance Covered - 100% after deductible	Contact Simply Blue for Coverage	Contact Simply Blue for Coverage
Inpatient Consultations	Contact BCN for Coverage	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	Contact BCN for Coverage	100% after in-network deductible	80% after out-of-network deductible

Alternatives to Hospital Care			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Skilled Nursing Care	Covered - 100% after deductible up to 45 days per calendar year	Must be in a participating skilled nursing facility 100% after in-network deductible Limited to a maximum of 120 days per member per calendar year	Must be in a participating skilled nursing facility 100% after in-network deductible Limited to a maximum of 120 days per member per calendar year
Hospice Care	Covered - 100% after deductible	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home Health Care	Covered - 100% after deductible	Must be medically necessary Must be provided by a participating home health care agency 100% after in-network deductible	Must be medically necessary Must be provided by a participating home health care agency 100% after in-network deductible
Infusion Therapy	Contact BCN for Coverage	Must be medically necessary Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) May use drugs that require preauthorization-consult with your doctor 100% after in-network deductible	Must be medically necessary Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) May use drugs that require preauthorization-consult with your doctor 100% after in-network deductible

Surgical Services			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Surgery - includes all related surgical services and anesthesia	Covered - 100% after deductible	Must be performed at a participating ambulatory surgery facility 100% after in-network deductible	Must be performed at a participating ambulatory surgery facility 100% after out-of-network deductible
Presurgical Consultations	Contact BCN for Coverage	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary Male Sterilization - See Preventive Services section for voluntary female sterilization	Covered - Male - 50% after deductible	100% after in-network deductible	80% after out-of-network deductible
Elective Abortion	Not Covered	Not Covered	Not Covered
Human Organ Transplants			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Human Organ Transplant (subject to medical criteria)	Covered - 100% after deductible	Must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) 100% (no deductible or copay/coinsurance)	Must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) 100% (no deductible or copay/coinsurance) - in designated facilities only.
Bone Marrow Transplants	Contact BCN for Coverage	Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) 100% after in-network deductible	Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) 80% after out-of-network deductible
Specified oncology clinical trials	Contact BCN for Coverage	100% after in-network deductible **Note**: BCBSM covers clinical trials in compliance with PPACA	80% after out-of-network deductible **Note**: BCBSM covers clinical trials in compliance with PPACA
Kidney, Cornea and Skin Transplants	Contact BCN for Coverage	100% after in-network deductible	80% after out-of-network deductible

Reduction Mammoplasty (subject to medical criteria)	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Male Mastectomy (subject to medical criteria)	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Orthognathic Surgery (subject to medical criteria)	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Behavioral Health Services (Mental Health and Substance Use Disorder)			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Inpatient Mental Health Care	Covered - 100% after deductible	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Residential Substance Use Disorder	Covered - 100% after deductible	Covered mental health services must be performed in a residential psychiatric treatment facility Treatment must be preauthorized Subject to medical criteria 100% after in-network deductible	Covered mental health services must be performed in a residential psychiatric treatment facility Treatment must be preauthorized Subject to medical criteria 80% after out-of--network deductible
Outpatient Mental Health Care	Covered - 100% after deductible **Note**: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing. Includes online visits.	<u>Facility and clinic:</u> 100% after in-network deductible <u>Physician's Office:</u> 100% after in-network deductible **Note**: Online visits by a non-BCBSM selected vendor are not	<u>Facility and clinic:</u> 100% after in-network deductible in participating facilities only

		covered.	Physician's Office: 80% after out-of-network deductible Note: Online visits by a non-BCBSM selected vendor are not covered.
Outpatient Substance Use Disorder	Covered - 100% after deductible	In approved facilities only 100% after in-network deductible	In approved facilities only 80% after out-of--network deductible (in-network cost-sharing will apply if there is no PPO network)
Applied Behavioral Analysis (ABA) treatment **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Through age 18 Covered - 100% after deductible	When rendered by an approved board-certified behavioral analyst - is covered through the age 18, subject to preauthorization 100% after in-network deductible	When rendered by an approved board-certified behavioral analyst - is covered through the age 18, subject to preauthorization 100% after in-network deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.	100% after in-network deductible	80% after out-of-network deductible
Other Covered Services			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Allergy Testing and Therapy	Covered - 100% after deductible	100% after in-network deductible	80% after out-of-network deductible
Allergy office visits	Covered - 100% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage

Allergy Injections	Covered - 100% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Chiropractic Spinal Manipulation	When referred - Covered - 100% after deductible; Up to 30 visits per year	And Osteopathic Manipulative Therapy $30 copay per visit; combined 12 visit per member per calendar year **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	And Osteopathic Manipulative Therapy 80% after out-of-network deductible; combined 12 visit per member per calendar year
Outpatient Therapy/Rehabilitation	Subject to meaningful improvement within 60 days - Covered - 100% after deductible; limited to 60 visits per calendar year for any combination of therapies.	100% after in-network deductible; combined 30 visit per member per calendar year	80% after out-of-network deductible; combined 30 visit per member per calendar year **Note**: Services at non participating outpatient physical therapy facilities are not covered.

Other Covered Services Continued			
	Blue Care Network HMO	**Simply Blue PPO In-Network**	**Simply Blue PPO Out-of-Network**
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered - 50% after deductible	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Durable Medical Equipment	Covered - 50% after deductible	100% after in-network deductible **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM. **Note**: Reference the Find A Doctor tool at BCBSM.com for in-network Durable Medical Equipment providers.	80% after out-of-network deductible **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM. **Note**: Reference the Find A Doctor tool at BCBSM.com for in-network Durable Medical Equipment providers.
Prosthetic and Orthotic Appliances	Covered - 50% deductible	100% after in-network deductible **Note**: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers	80% after out-of-network deductible **Note**: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers
Private Duty Nursing Care	Contact BCN for coverage	50% after in-network deductible	50% after in-network deductible
Outpatient Diabetes Management Program (ODMP)	Contact BCN for coverage	100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible

		Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider	**Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider
Diabetic Supplies	Covered - 100% after deductible **Note**: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100% after in-network deductible **Note**: When you purchase diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after out-of-network deductible **Note**: When you purchase diabetic supplies via mail order you will lower your out-of-pocket costs.

~ 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 visit the Blue Cross Blue Shield website at bcbsm.com

Prescription Drug Coverage					
	Blue Care Network	**Simply Blue: 90-day retail network pharmacy**	**Simply Blue: In-network mail order provider**	**Simply Blue: In-network pharmacy (not part of the 90-day retail network)**	**Simply Blue: Out-of-network pharmacy**
Tier 1 - Generic Drugs	1A - Value Generics: $10 copay after deductible 1B - Generics: $30 copay after deductible	1 to 30-day period: $10 copay 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: $20 copay	1 to 30-day period: $10 copay 31 to 60-period: $20 copay 61 to 83-day period: $20 copay 84 to 90-day period: $20 copay	1 to 30-day period: $10 copay 31 to 60-period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage	1 to 30-day period: $10 copay plus an additional 25% of the BCBSM approved amount 31 to 60-period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage
Tier 2 - Preferred Brand-Names Drugs	$60 copay after deductible	1 to 30-day period: $40 copay 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: $110 copay	1 to 30-day period: $40 copay 31 to 60-day period: $80 copay 61 to 83-day period: $110 copay 84 to 90-day period: $110 copay	1 to 30-day period: $40 copay 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage	1 to 30-day period: $40 copay plus an additional 25% of the BCBSM approved amount 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage

Prescription Drug Coverage Continued					
	Blue Care Network	**Simply Blue: 90-day retail network pharmacy**	**Simply Blue: In-network mail order provider**	**Simply Blue: In-network pharmacy (not part of the 90-day retail network)**	**Simply Blue: Out-of-network pharmacy**
Tier 3 - Non-Preferred Drugs	$80 copay after deductible	1 to 30-day period: $80 copay 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: $230 copay	1 to 30-day period: $80 copay 31 to 60-day period: $160 copay 61 to 83-day period: $230 copay 84 to 90-day period: $230 copay	1 to 30-day period: $80 copay 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage	1 to 30-day period: $80 copay plus an additional 25% of the BCBSM approved amount 31 to 60-day period: No coverage 61 to 83-day period: No coverage 84 to 90-day period: No coverage
Tier 4 - Preferred Specialty	20% coinsurance of the BCN approved amount (max copay $200) - Specialty drugs are covered only when obtained from the BCN exclusive Specialty Pharmacy Network	Contact Simply Blue for coverage	Contact Simply Blue for coverage	Contact Simply Blue for coverage	Contact Simply Blue for coverage
Tier 5 - Non Preferred Specialty	20% coinsurance of the BCN approved amount (max copay $300) - Specialty drugs are covered only when obtained from the BCN exclusive Specialty Pharmacy Network	Contact Simply Blue for coverage	Contact Simply Blue for coverage	Contact Simply Blue for coverage	Contact Simply Blue for coverage

~ 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 visit the Blue Cross Blue Shield website at bcbsm.com

Waive Medical Coverage (Cash In Lieu)

Full-time employees (7+ hours per day) not electing medical insurance benefits will be provided One Hundred Eighty Dollars ($180.00) cash payment per month added to gross pay. In order to receive this benefit, members must complete a waiver to determine eligibility.

2022-2023 Medical Contributions

Full Year Medical Coverage Contribution

Rates below are based on 12 months of coverage beginning July 1, 2022 through June 30, 2023.

If you are making a change to your plan coverage during open enrollment or due to a qualifying event, please contact Cristal Koehn-Socia at crikoe@myfitz.net for prorated rates.

Full Time (7+ hours per day) - 26 pays			
	Single	**2 Person**	**Family**
Blue Care Network HMO	$0 per pay	$70.96 per pay	$38.94 per pay
Simply Blue PPO	$42.03 per pay	$188.45 per pay	$185.81 per pay
Full Time (7+ hours per day) - 22 pays			
Blue Care Network HMO	$0 per pay	$83.86 per pay	$46.02 per pay
Simply Blue PPO	$49.68 per pay	$222.71 per pay	$219.59 per pay

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

Blue Cross Online Visits is virtual care that's always there

Health care is at your fingertips 24/7 from anywhere in the U.S. with Blue Cross Online Visits. A convenient and affordable virtual visit with a U.S. board-certified doctor or nurse practitioner who you can trust is an option for you and your family.

Medical care

When your primary care provider isn't available, everyone on your health care plan can use Blue Cross Online Visits for minor illnesses. It's easy to find providers who specialize in children using the Children's Medical feature.

You don't need an appointment and the average wait time to see a provider is five minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Behavioral health care

During a confidential virtual behavioral health visit, you can talk to a licensed therapist or a U.S. board-certified psychiatrist. Behavioral health care is helpful when you're dealing with stressful situations or issues such as grief, anxiety or depression.

Therapy and Psychiatry are available by appointment and many providers offer extended hours, including nights and weekends.

Get started with care that's always there

Download the BCBSM Online Visits app or visit bcbsmonlinevisits.com. When you update or create your account, choose your plan name and enter your enrollee ID so your coverage is applied correctly. Family members ages 18 and older must create their own accounts.

You'll see your cost before you start your visit. Be sure you've added your Blue Cross health plan information to your Blue Cross Online Visits account.

Call 1-844-606-1608 with any questions about your account.

2022-2023 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 non-covered 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.

2022-2023 Dental Contributions

The premium cost for dental insurance is paid for by the Fitzgerald Board of Education for all full time (7+ hours per day) 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.

If you are a part-time employee (less than 7 hours per day), contact Cristal Koehn-Socia at 586-757-1751 for per pay contributions.

2022-2023 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	**(Combined with Dental) In-Network**	**Vision Only (No Dental) In-Network**
Eye Exam	None	$5.00 Copay
Prescription Glasses (Lenses/Frames)	None	Combined $7.50 Copay
Medically Necessary Contact Lenses	Non	$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
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)
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)

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
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)

2022-2023 Vision Contributions

The premium cost for 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 less than 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
2023	$3,850	$7,750
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 HSA 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

Flexible Spending Account - Varipro

Information found in the FSA Information Sheet, attached to enrollment email.

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, 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.

<u>When Can You Join A Medicare Drug Plan?</u>
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.

<u>What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?</u>
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.

<u>When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?</u>
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.

<u>For More Information About This Notice Or Your Current Prescription Drug Coverage:</u>

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>8. State
Michigan</td><td colspan="2">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.*