EASTPOINTE
COMMUNITY SCHOOLS

2019 Benefit Guide

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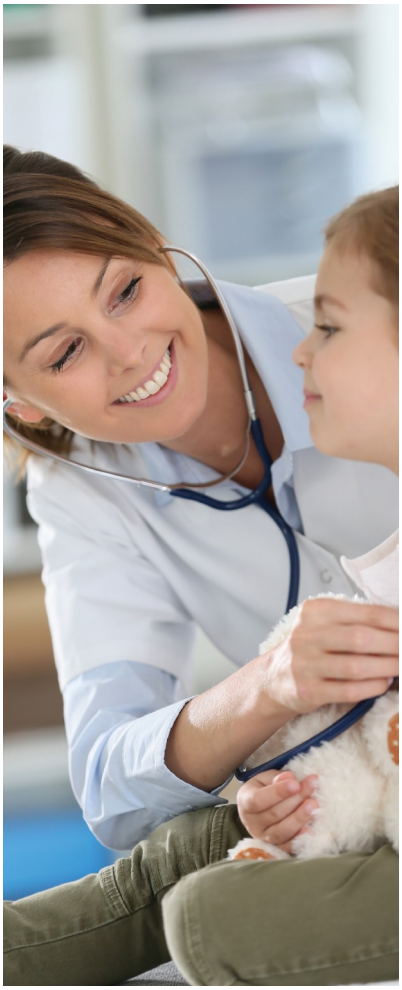
Information about Medicare

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the attached Creditable Coverage Notice for details.

2019 Benefit Guide



Eastpointe Community Schools offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This Benefit Guide will provide an overview of the benefit plans that Eastpointe Community Schools sponsors. This is your opportunity to enroll and/or change your benefit elections. This includes:

- Enrolling yourself and/or your dependents in coverage.
- Terminating coverage for yourself and/or your dependents.
- Changing your plan elections.
- Enrolling in the Flexible Spending Account(s).

After reviewing this Benefit Guide, you will need to make a decision about the benefits you want to elect for 2019.

How to Enroll

- Review the benefits detailed in this Benefit Guide.
- Review and make your benefit elections on the 2019 Benefit Election Form.
- Return the 2019 Benefit Election Form to Human Resources by the deadline date.
- You will not be able to change your benefit elections until the next open enrollment period unless you have a qualified change in status.

Medicaid Expansion

Medicaid provides health coverage for low income individuals including children, pregnant women, parents of eligible children, people with disabilities and the elderly needing nursing home care. The eligibility rules are different for each State.

Health care reform expands the Medicaid program to include individuals between the ages of 19 to 65 (parents, and adults without dependent children) with incomes up to 138% the Federal Poverty Level. This is important because people who were not previously eligible for Medicaid may now be eligible under the expansion.

Michigan passed the Medicaid expansion in early 2014. Depending on your household income you may be better off enrolling in Medicaid rather than our medical plan. To see if your household qualifies for Medicaid, please visit:

- **https://www.healthcare.gov - Find information about all aspects of the Affordable Care act, including links to state websites and coverage applications.**
- **www.healthcare.gov/do-i-qualify-for-medicaid/ - For information on Medicaid eligibility.**
- **https://www.medicaid.gov/ - For more information on Medicaid.**

Making Mid-Year Changes

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year (January 1—December 31). The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.
- Electing coverage under your state's Marketplace (also known as the Exchange) during annual enrollment or as a result of a special enrollment.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

Reminder: Most Americans must have medical coverage to meet the individual mandate under the Affordable Care Act (ACA) or they must pay an IRS tax. Enroll in one of the medical plans offered by Eastpointe Community Schools to ensure that you meet your individual mandate and avoid the IRS tax.

Employee Contributions

Your contributions for medical coverage will be deducted from your paycheck on a pre-tax basis in the plan year. **There is no cost to enroll in the dental and vision plans.**

Eastpointe Community Schools has a Section 125 Premium Conversion Plan. Contributions taken on a pre-tax basis are NOT subject to federal, state, and FICA taxes. As a result, your net contributions will be less due to the pre-tax savings under the Section 125 Premium Conversion Plan. The amount of savings will vary depending on your individual contribution and income tax bracket. Additionally, pre-tax contributions will slightly impact your social security contributions.

Monthly payroll deductions for 2019 are shown in the chart below.

Employee Monthly Contributions			
Coverage	**Single**	**Two Person**	**Family**
Medical PPO	$121.12	$288.08	$360.40

Medical & Dental Opt-Out

If you choose to decline medical and/or dental coverage, and decide not to enroll in the Eastpointe Community Schools' plans, you will be eligible for an Opt-Out Bonus. The annual Opt-Out Bonus amounts are shown in the chart below.

To be eligible for the medical Opt-Out Bonus, you must complete the Opt-Out Attestation of Other Group Health Insurance Coverage on the Benefit Election Form.

Should you experience an IRS qualified mid-year change in status, you will be eligible to enroll in the Eastpointe Community Schools plan if you notify Human Resources within 30 days of losing the coverage. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

Coverage	Annual Opt-Out Bonus
Medical	$2,400 Your are not eligible for the Medical Opt-Out Bonus if both you and your spouse work at Eastpointe Community Schools
Dental	If opting out of dental $350 will be deposited in your Health Care Reimbursement Account. If your spouse is an employee of the district, you will be enrolled in the Buy-Down plan and $150 will be deposited in your Health Care Reimbursement Account.

Medical/Prescription Drugs

Eastpointe Community Schools offers a Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization medical/prescription drug plan. Eastpointe Community Schools and you both contribute toward the cost for medical/prescription drug coverage.

The Blue Cross Blue Shield of Michigan medical plan is "self-funded". This means that each medical claim is paid directly by Eastpointe Community Schools instead of an insurance company. Blue Cross Blue Shield of Michigan (BCBSM) is paid to manage the administration of the plan and your claims.

By self-funding, Eastpointe Community Schools assumes a managed/capped financial risk, but in turn is able to adjust contributions and rates according to plan usage. Therefore, the more favorable our usage is, the more money available to keep cost increases to a minimum for our employees.

Blue Cross Blue Shield of Michigan—PPO

- Our Blue Cross Blue Shield of Michigan (BCBSM) PPO plan provides comprehensive coverage. "PPO" stands for Preferred Provider Organization. As a BCBSM PPO member, you have access to the worldwide network of BCBSM PPO providers. To find BCBSM PPO providers, visit the BCBSM website.
- You get the most benefits when you receive care from PPO providers. You don't need to choose a Primary Care Physician with a PPO—you can see any provider you want to see, even a specialist. There's a lot of freedom with PPO plans.
- You can see non-PPO providers, but your benefits will be reduced and you'll pay more out-of-pocket.
- If you visit a non-PPO provider, it will be in your financial interest to receive care from a BCBSM participating provider. That's because the participating provider must accept BCBSM's approved amount—they can't balance bill you for more than your deductible and coinsurance. A non- participating provider can balance bill you whatever amount s/he thinks is fair–there's no limit to what you can be charged.
- Coverage at non-participating hospitals (those who do not participate with BCBSM) is limited to services needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital services or services received at mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

Managing your health plan online has never been easier.
With the new member site, you have access to:

- **Personal snapshot of your benefits**
- **Single user ID for life**
- **Find doctors and hospitals**
- **Evaluate doctors and hospitals for quality and cost**
- **Helpful patients reviews**
- **Virtual ID card**

Register now at www.bcbsm.com (You'll need your BCBSM ID card)

Medical/Prescription Drugs

Prescriptions Drugs

The BCBSM medical plan include prescription drug coverage.

The BCBSM formulary is a continually updated list of Federal Drug Administration approved medications that represent each therapeutic class of drugs. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. You may access the formulary listing on the BCBSM website.

This formulary listing designates requirements, including Prior Authorization and Step-Therapy, that must be followed in order to obtain a specific medication. Prior Authorization and Step-Therapy monitor certain medications to ensure that covered individuals receive the most appropriate and cost-effective drug therapy. Both of these are explained below.

Prior Authorization

Certain prescription drugs require prior authorization (prior approval), which means that your provider will need to contact BCBSM before you fill your prescription. If BCBSM does not get the necessary information to satisfy the prior authorization, BCBSM may not cover the drug. Drugs selected include those with a potential for alternative use or misuse (for example, growth hormones).

Step Therapy

In some cases, BCBSM requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, BCBSM may require your doctor to prescribe Drug A first. If Drug A does not work for you, then BCBSM will cover Drug B.

The *Prior Authorization/Step Therapy Drug List* details the prescriptions which fall under this provision and the criteria for each prescription. You can find the *Prior Authorization/ Step Therapy Drug List* at www.bcbsm.com. Click on "I am a Member," then click on "Prescription Drugs."

If Express Scripts informs you your doctor failed to get Prior Authorization, you can contact your physician's office right from the pharmacy and remind them to call the Pharmacy Clinical help desk at (800) 437-3803. This will reduce waiting time in the pharmacy on your part and prevent you from paying out-of-pocket for medications that should be covered as a part of your prescription program.

Specialty Prescription Program

Specialty drugs are prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions, including but not limited to:

- Asthma
- Cancer
- Chronic Kidney Failure
- Hepatitis C
- HIV/AIDS
- Rheumatoid Arthritis
- Infertility
- Multiple Sclerosis
- Organ Transplants
- Osteoporosis
- Psoriasis

If your medication is included in the specialty drug list, you can get your prescription drugs delivered to your home by mail ordering them through Walgreens Specialty Pharmacy. You can call Walgreens at (866) 515-1355 to order or visit them online at www.walgreensspecialtyrx.com. You may also fill your prescription at a retail pharmacy, but not all pharmacies dispense specialty drugs, so call your pharmacy to verify if they can fill your prescription.

Medical/Prescription Drugs

Retail 90 & Mail Order Programs

This program allows you to receive a 90-day prescription refill for maintenance medication from participating walk-in pharmacies for one copayment. To receive a 90-day refill at a participating retail pharmacy, these conditions must be met:

- State laws approve the dispensing of a 90-day supply for your medication.
- The prescription is written for a 90-day supply.
- The prescription is a refill for a medication that you have been taking for at least 60 of the past 120 days under your BCBSM plan.
- The prescription strength of the medication has not changed within the past 60 days.

The Plan also offers a convenient and cost-saving prescription drug program for long-term maintenance medication through Express Scripts. By using the Express Scripts Mail Order Prescription Drug (MOPD) program, you pay one copayment for a 90-day supply of maintenance medication under the plan. To participate, have your doctor write you a 90-day prescription, then mail an enrollment form or complete the online enrollment form. Your order will be sent to your home via UPS or First Class Mail. Reorder information will be included in your prescription shipment.

Maintenance medication is taken on a regular or long-term basis. For example, the following conditions may be treated with maintenance medication: High blood pressure, Ulcers, Arthritis, Heart or Thyroid conditions, Emphysema, and Diabetes.

Medical/Prescription Drugs

Medical Plan and Coordination

In Michigan, you have the choice between two types of medical benefit options on an auto insurance policy:

- Non-Coordinated Coverage (Auto Insurance pays primary)
- Coordinated Coverage (Auto Insurance pays secondary)

It is important to understand the medical coverage election on your auto insurance coverage. Whether your auto coverage is coordinated or non-coordinated is typically determined by how the medical plan coordinates with auto insurance. Auto insurers may give members a discount if their medical plan pays primary to auto insurance or may increase your auto premiums if your medical plan pays secondary to the auto insurance.

If you receive a letter from your auto insurance carrier asking you to verify that your health insurer is the primary payer (Coordinated), you will need to take the following steps:

- BCBSM plans will generally be primary to your no-fault auto insurance
- Call the Customer Service number listed on the back of your medical ID card to obtain this information

Selecting automobile insurance coverage can get complicated and should be discussed with an auto insurer/ agent. There are many different accident scenarios that come into play in determining how auto insurance will pay/coordinate with a group medical plan. It can be very difficult to ascertain which plan will pay primary versus secondary for every situation.

Getting Health Care Online in 2019

Our BCBSM medical plan includes a 24 hour a day / 7 days a week / 365 day a year online program allowing you to access quality health care no matter where you are in the U.S. When you use Blue Cross Online Visits℠, you will have access to online medical and behavioral health services. The cost is the same as your office visit copay. For employees in the CDHP, the cost will apply to your deductible and coinsurance.

Online health care does not replace your relationship with your primary care doctor. But, these virtual visits allow you to see a doctor if you are traveling, home with a sick child or your primary care doctor is not available

You and your covered family members can see and talk to:

- **A board certified physician for minor illnesses such as a cold, flu, sore throat, sinus or respiratory infection.**
- **A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief.**

You can access online visits by:

- **Mobile – Download the BCBSM Online Visits℠ app**
- **Web – Visit bcbsmonlinevisits.com**
- **Phone – Call 1-844-606-1608**

You will need to create an account profile and add your Blue Cross health plan information.

We are pleased to provide this service to covered employees and their enrolled dependents. For an approved absence from work, an in-person visit to a physician and corresponding note will be required.

Medical/Prescription Drugs

	In-Network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	$250 for one member $500 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$500 for one member $1,000 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.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for online visits • $20 copay for chiropractic services and osteopathic manipulative therapy • $100 copay for emergency room visits • $20 copay for urgent care visits	$100 copay for emergency room visits
Coinsurance Amounts (percent copays) **Note**: the coinsurance amounts apply once the deductible has been met	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums – applies to coinsurance amounts for all covered services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 for one member $2,000 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 coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost -sharing amounts for prescription drugs, if applicable	$6,350 for one member $12,700 or the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member $25,400 or 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.
Lifetime dollar maximum	None	

Medical/Prescription Drugs

	In-Network	Out-of-Network
Preventive Care Services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screen and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and childcare visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% 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	
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Medical/Prescription Drugs

	In-Network	Out-of-Network
Physician Office Services		
Office visits – must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits – by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible
Emergency Medical Care		
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic Services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity Services—provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
Hospital Care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies. **Note**: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible Unlimited Days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Medical/Prescription Drugs

	In-Network	Out-of-Network
Alternatives to Hospital Care		
Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care	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)
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • 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	80% after in-network deductible	80% after in-network deductible
Surgical Services		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see "**Preventive care services**."	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible
Human Organ Transplants		
Specified human organ transplants – 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)	100% (no deductible or copay/coinsurance) – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Medical/Prescription Drugs

	In-Network	Out-of-Network
Mental Health Care and Substance Use Disorder Treatment		
Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.		
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic • Physician's office	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**
	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment – in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

BCBSM—Save money and live healthier with Blue365

Blue Cross Blue Shield of Michigan members are eligible for special savings on a variety of healthy products and services from businesses in Michigan and across the United States.

Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness: Health magazines, fitness gear and gym memberships.**
- **Healthy eating: In-store discounts, cookbooks, cooking classes and weight-loss programs.**
- **Lifestyle: Travel and recreation.**
- **Financial Health: Pet insurance and cell phone providers.**
- **Personal care: Lasik and eye care services, dental care and hearing aids.**

Show your BCBSM ID card at the participating local retailers or use an offer code online to take advantage of these savings. You can view all savings in one place through your member account at bcbsm.com.

Medical/Prescription Drugs

	In-Network	Out-of-Network
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered
Other Covered Services		
Outpatient Diabetes Management Program (ODMP) **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**: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **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.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Prescription Drugs		
Retail (up to a 30 day supply)	$7 Generic $35 Formulary $70 Non-Formulary Brand	Prescriptions reimbursed at 75% of approved amount less in-network copays
Mail-Order (Up to a 90-day supply)	$7 Generic $35 Formulary Brand $70 Non-Formulary Brand	Not Covered

Dental

Our dental plan is self-funded and administered by ADN Administrators Inc. Eastpointe Community Schools pays the full cost for dental coverage. If you enroll in medical coverage, you will be enrolled in dental coverage. If your spouse is an employee of the district, you will be enrolled in the Buy-Down plan, and $150 will be deposited in your Healthcare Reimbursement Account.

ADN Administrators utilizes two Preferred Provider Organization (PPO) networks—ADN Dental Network and Dentemax. Our dental plan allows freedom of choice, you may receive treatment from any licensed dentist or dental specialist. However, utilization of a PPO dental provider will substantially reduce your out-of-pocket dental expenses and overall dental benefit costs. Participating PPO dentists will adhere to ADN's processing policies and are prohibited from billing a patient above the pre-negotiated fee, accepting billing under these terms as payment in full and there are no claim forms to submit for reimbursement.

Non-participating dentists may not agree to bill ADN directly. If your dentist requires you to pay out-of-pocket, request that he/she submit the claim for your reimbursement. They may either submit the claim or give it to the patient for submission. ADN can issue benefit payment directly to you.

Plan Year: January 1 through December 31	Core Plan In-Network Benefits	Buy-Down Plan In-Network Benefits
Maximum Benefits		
Annual Maximum—per eligible individual for covered Class I, II and III services	$1,500	$1,500
Class I—Preventative Services		
Oral Examinations—Twice per plan year Bitewing X-Rays—Once per plan year Prophylaxis (Cleaning)—Twice per plan year Topical Application of Fluoride—Twice per plan year to age 19 Full-Mouth Series or Panoramic X-Rays—Once per 60 months All Other X-Rays Space Maintainers—Once per area per lifetime, up to age 19	80% coverage	50% coverage
Class II—Restorative Services		
Periodontal Maintenance—Twice per plan year Composite & Amalgam fillings**—Once per tooth surface per 12 months Root Canal therapy Periodontal Root Planing—Once per quadrant per 24 months Periodontal Surgery—Once per quadrant per 36 months Oral Surgery & Extractions General Anesthesia or IV Sedation—Medically necessary & with covered oral surgery Denture Repair and Adjustment Denture Reline or Rebase—Once per 36 months, per arch	80% coverage	50% coverage
Class III—Major Services		
Inlays, Onlays, Crowns**—Once per permanent tooth in 60 months Complete & Partial Removable Dentures**—Once per arch per 60 months Fixed Partial Dentures (Bridges)**—Once per arch per 60 months Addition of Teeth to Partial Dentures	80% coverage	50% coverage
Services Not Covered		
Sealants Orthodontics Implants & Restoration over implants TMJ/TMD Treatment Occlusal Guards	Deductible—None Missing Tooth Clause—None 12 Month Billing Limitation Waiting Periods—None Coordination of Benefits—Standard	

** Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies ** Prosthetics are considered on seat/delivery date

****Note—Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Predetermination is strongly encouraged for all non–emergency dental treatment exceeding $250 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

Vision

Our vision coverage is insured by Davis Vision. Per our Group Policy, all employees are enrolled in vision coverage. Eastpointe Community Schools pays the full cost for vision coverage.

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering: paid-in-full eye examination and eyeglasses. Frame Collection: Your plan includes a selection of name brand frames that are completely covered in full[1].

You will receive the maximum benefits when you receive care from an in-network provider. If you choose to receive care from an out-of-network provider, you will pay more out-of-pocket because out-of-network providers can charge whatever amount they think is fair for the service they provide.

Vision Services	In-Network	Out-of-Network
Exam—Once Every 12 Months		
Eye Exam—Includes dilation when professionally indicated	$0 Copay, Covered in full	Reimbursed up to $30
Frames—Once Every 24 Months		
Frames	$0 Copay, Covered in full—any fashion level frame from Davis Vision's Collection (retail value up to $100) OR $68 allowance toward any frame from provider	Reimbursed up to $30
Lenses—Once Every 24 Months		
Single	$0 Copay, Covered in full	Reimbursed up to $25
Lined bifocal	$0 Copay, Covered in full	Reimbursed up to $35
Trifocal	$0 Copay, Covered in full	Reimbursed up to $45
Lenticular	$0 Copay, Covered in full	Reimbursed up to $60
Contact Lenses (In lieu of glasses)—Once Every 24 Months		
Elective Contacts	$0 Copay, $150 allowance toward any contacts from provider's supply	Reimbursed up to $75
Medically Necessary Contacts		Reimbursed up to $225

1 The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.

Life and AD&D

Basic Life and Accidental Death and Dismemberment

Eastpointe Community Schools provides full-time employees with Basic Life and AD&D insurance, insured by Unum, and pays the full cost of this benefit.

Life insurance is extremely important if you have family members that depend on your income. Life insurance provides financial security for you and your dependents should you die while an employee of this district. Accidental Death and Dismemberment (AD&D) insurance pays an additional benefit if your death is a result of an accident. In addition, AD&D insurance will pay a portion of the benefit for a loss of limb, eyesight or both, if the loss is a direct result of an accident.

Review the Union Contract for your Basic Life and AD&D benefit amount.

Benefits reduce based on age. Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.

Reminder: Contact the Life and AD&D carrier within 31 days of loss of coverage for information and instructions on how to apply for continuation of coverage.

Optional Life and Accidental Death and Dismemberment

Employees who want to supplement their group life insurance benefits may purchase additional coverage through Unum. When you enroll yourself in this benefit, you pay the full cost through pre-tax payroll deductions.

You can elect coverage in the amounts of either:

- $35,000
- $70,000
- $105,000

Evidence of insurability is required if you waive coverage when you are initially eligible and choose to enroll at a late date; and for any increase in coverage. Benefits reduce based on age. Coverage effective dates and increases in coverage may be delayed if you are disabled or have a life threatening condition on the date coverage is scheduled to take effect. Review the carrier certificate/ benefit booklet for details.

Optional Life/AD&D Rates	
Age	**Monthly Rate per $1,000 of Coverage**
<30	$0.095
30-34	$0.115
35-39	$0.115
40-44	$0.165
45-49	$0.235
50-54	$0.365
55-59	$0.535
60-64	$0.685
65-69	$1.295
70 +	$2.085

Calculate your monthly cost by dividing your election amount by 1,000, then multiply by the rate in the chart above this amount equals your monthly cost.

(Example based on age 35: $35,000 ÷ 1,000 = 35 x $0.115 = $4.03 monthly cost)

A Note About Imputed Income: Any employee whose company-paid life insurance amount exceeds $50,000 will have the value of the insurance over $50,000 applied as imputed income when calculating income taxes. These amounts are taxable to you and will be withheld as payroll tax and will be reported on your W-2. The monthly rate of imputed income is determined by multiplying the age-banded rate by the amount of insurance over $50,000. These rates are found on Table 1 of IRS Code Section 79. For more information, consult your tax advisor.

Flexible Spending Accounts

Flexible Spending Accounts let you pay for health care and day care expenses with tax-free dollars. They help you stretch your money and reduce your federal, state and Social Security taxes. How much you save depends on how much you pay in income tax.

There are two types of accounts under this plan: a Health Care Reimbursement Account (HCRA) and a Dependent Care Reimbursement Account (DCRA). Enroll in one account or both. Employee Benefit Concepts, Inc. (EBC) administers the plan for us.

Flexible Spending Accounts 2018 Maximum Annual Contribution

Health Care: $2,650
Dependent Care: $5,000, or $2,500 if married and filing separate tax returns

With a HCRA or DCRA, you decide before the start of the year how much to contribute to each account. Your contributions are withheld in equal amounts from your paychecks throughout the year. The money goes into an account (s) set up in your name. Claim the money in your account(s) by using a debit card for HCRA claims only or you can file a claim form for reimbursement. You must enroll/re-enroll in the plan to participate for the plan year January 1 to December 31, 2019.

How the Accounts Save You Money	Without a HCRA or DCRA	With a HCRA or DCRA
Gross Salary	$25,000	$25,000
Less Annual Amount Deposited into HCRA / DCRA	$0	($2,000)
Taxable Income	$25,000	$23,000
Less Annual Taxes (assumed at 25%)	($6,250)	($5,750)
Net Salary	$18,750	$17,250
Less Out-of-Pocket Health Care and/or Dependent Care Expenses for the Year	($2,000)	N/A
Disposable Income	$16,750	$17,250
Tax Savings	None	$500

Health Care Reimbursement Account (HCRA)

The HCRA helps you pay for medical, dental, and vision bills that are not covered by insurance. You can put up to $2,650 into the HCRA in 2019. The full amount will be available January 1, 2019.

When you enroll in the HCRA, you will receive a debit card—with one swipe, you can pay eligible expenses at the point-of-service. Just use the card like you would a credit card. Other advantages of the debit card:

- It deducts payments directly from your account.
- You don't have to file claim forms and wait for reimbursement.
- The debit card works when you buy medical goods or services from a merchant with a special medical Merchant Category Code. The code tells the IRS that you used your debit card for an approved medical expense. Some places do not have a medical Merchant Category Code, but they have a special inventory control system that will still let the IRS know that you've used your card for an approved purchase. So your card will work as long as the place you are buying goods or services from has the medical Merchant Category Code or the special inventory control system.

Flexible Spending Accounts

Health Care Reimbursement Account (HCRA), continued

- If your merchant doesn't have either a medical Merchant Category Code or inventory control system, your purchase may not go through. If this happens, pay cash up-front and then file a claim for reimbursement with EBC.
- Keep in mind that if the amount you charge on your debit card is not a fixed copay amount like an office visit or prescription drug copay, you'll need to send your receipt to EBC to verify that it is an eligible expense. So, save those receipts! If you don't send in a receipt when EBC asks, your debit card will be de-activated.

If you have a cash register receipt that doesn't identify the drug, send other proof—you could send the receipt that shows the cost and the date you made the purchase, along with the box top that shows the price. Call EBC, our administrator, with questions at (248) 855-8040.

For a complete list of the expenses eligible for reimbursement, visit the IRS website at www.irs.gov/pub/ irs-pdf/p502.pdf.

Dependent Care Reimbursement Account (DCRA)

This account lets you pay eligible dependent care expenses with pre-tax dollars. Most child and elder care and companion services are eligible expenses too. Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves.
- Spending at least 8 hours a day in your home.
- Eligible to be claimed as a dependent on your federal income tax.
- Receiving care when you are at work and your spouse (if you are married) is at work or searching for work, is in school full-time, or is mentally or physically disabled and unable to provide the care.

In 2019, the most you can put into the DCRA is $5,000. But if both you and your spouse work, the IRS limits your maximum contribution to a DCRA.

- If you file separate income tax returns, the annual contribution amount is limited to $2,500 each for you and your spouse.
- If you file a joint tax return and your spouse also contributes to a DCRA, your family's combined limit is $5,000.
- If your spouse is disabled or a full-time student, special limits apply.
- If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000.

With a DCRA, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you'll be reimbursed as new deposits are made.

Eligible dependent care expenses can either be reimbursed through the DCRA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually the DCRA will save more money than the tax credit. But to find out what is best for you and your family, talk to your tax advisor or take a look at IRS publication 503 at http://www.irs.gov/publications/p503/index.html.

If you contribute to a DCRA, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Flexible Spending Accounts

For Both HCRA and DCRA

All claims must be incurred by December 31, 2019 for the 2019 plan year. Claims incurred prior to your enrollment in the plan are not eligible for reimbursement. All 2019 expenses must be submitted to Employee Benefit Concepts, Inc. (EBC) by March 31, 2020. You should consider submitting your expenses as they occur. This will help avoid year end processing delays.

Access your flexible benefit accounts anytime, anywhere. Go to MyFlexOnline.com, then:

Step 1

- Click on New User Registration link on the right side of the page.

Step 2

- Complete the required information.
- Click on Next, you will be asked to verify information about your employment, then you will create a User ID and Password.

Step 3

Once you have established your User ID and Password, you will be able to

- Upload claims electronically.
- Check claim status.
- Receive electronic account updates.
- Review your account balance.
- And much, much more, 24/7.

Access your account on your mobile phone, enter MyFlexOnline.com into your phone's internet browser, or use the MyFlexMobile app. Download the free MyFlexMobile app to your iPhone or Android smartphone, log into your MyFlexOnline account and:

- File a claim.
- Snap a photo of receipts and submit them instantly for payment.
- View transactions and account and card balances.
- Sign up for text message or email alerts about your account(s).

Use It or Lose It—Sounds Scary, Doesn't It?

IRS regulations state money remaining in HCRA or DCRA accounts at the end of the year must be forfeited. People call this the "use it or lose it" rule. This sounds scary, but don't let it keep you from enrolling in these accounts.

You can avoid losing money with some planning. Many out-of-pocket costs are predictable. If you say "Every year I pay my medical deductible", why not put the amount of your deductible into a HCRA and pay it with tax free money? Or if you pay $40 every month for a brand name drug, set aside $480 ($40 x 12 months) and pay the copays with tax free money.

Dependent care expenses can be budgeted ahead of time.

And remember that your tax savings are a "cushion." You must leave a balance of more than your tax savings to "lose". Let's say you deposit $1,000 in an account—you will save about $250 in taxes (with a 25% tax rate). *Even if you forfeit $250, you will still break even.*

Employee Assistance Program

Eastpointe Community Schools is pleased to offer this no-cost benefit through our life insurer, Unum and their partner, Work-life Balance Employee Assistance Program. An Employee Assistance Program (EAP) provides access to assistance and services that are available to aid in managing work, family, health or other personal issues.

When you or your family members have questions, concerns or emotional issues surrounding your personal or work life, you can contact the EAP for help. Unum's work-life balance EAP offers unlimited access to master's-level consultants by telephone, resources and tools online, and up to three face-to-face visits with a consultant for help with a short-term problem.

Services are available on a live basis 24 hours a day, 7 days a week, and your use of this service and the information you share is confidential, except when your safety or the safety of another individual may be at risk or as required by law.

Here are just some of the services you may receive:

- Locate child care and elder care services and obtain matches to the appropriate provider based on your or your family's preference and criteria. The consultant will even confirm space availability.
- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement.
- Work through complex, sensitive issues such as personal or work relationships, depression or grief, or issues surrounding substance abuse.
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation. You'll have access to an attorney for state-specific legal information and services. If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.

You also have unlimited website access at lifebalance.net where you can:

- Read booklets, life articles and guides
- View videos and online seminars, as well as listen to podcasts
- Subscribe to email newsletters
- Find information on parenting, retirement, finances, education and more

Call 800-854-1446 for assistance today,

or log on to: www.lifebalance.net

User ID and password: lifebalance

LifeWorks mobile app

Your use of this service and the information you share is confidential, except when your safety or the safety of another individual may be at risk.

Travel Assistance

Eastpointe Community Schools is pleased to offer this no-cost benefit through our life insurer, Unum and their partner, Assist America.

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre- qualified, English-speaking and Western-trained medical providers anywhere in the world.

Whenever you travel 100 miles or more from home – to another country or just another city – be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use travel assistance phone number to access:

- Hospital admission assistance
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor child
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Whether traveling for business or pleasure, one phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

With the Assist America Mobile App, you can:

- Call assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-trip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy
- Read Assist Alerts

Download and activate the app today from the Apple App Store or Google Play.

Reference Number:
01-AA-UN-762490

Optional Benefits

AFLAC

Eastpointe Community School is now making the following Aflac insurance policies available to its employees:

- Accident: For covered accident, Aflac policyholders received cash benefits for use as they see fit. This plan helps provide a financial cushion if an accident occurs.
- Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policies are designed to pay cash benefits that can be used to help offset cancer-related expense and to help with a variety of daily living expenses.
- Critical Illness: Helps with the medical expense related to a covered serious health event.
- Term Life Insurance: Aflac's 10-year, 20-year, or 30-year term life insurance policies are available to purchase. Life insurance protection is offered up to $250,000 ($100,000 for applicants ages 51–70).

Aflac offers the following benefits Eastpointe Community Schools employees:

- Aflac is different from major medical insurance; it's insurance for daily living.
- Aflac pays you cash benefits, unless assigned, to use as you see fit.
- Aflac benefits can help with unexpected expenses.
- Aflac insurance policies belong to you—not your company.
- Aflac offers competitive rates.
- Aflac processes claims quickly—usually within 4 days.

For more information about policy benefits, limitations, and exclusions, please call your Aflac insurance agent/producer, Patrick Wolff at 586-321-7806 or email patrick_wolff@us.aflac.com.

Contact Information

Provider	Benefit	Contact Information
Blue Cross Blue Shield of Michigan (BCBSM)	Medical/Rx	877-790-2583 www.bcbsm.com
ADN Administrator	Dental	248-901-3705 888-236-1100 www.adndental.com
Davis Vision	Vision	800-282-8951 www.davisvision.com
Unum	Life/AD&D	800-275-8686 www.unum.com
Employee Benefits Concepts	Flexible Spending Accounts	248-855-8040 ext. 302 248-855-2454 FAX www.myflexonline.com or email claims to: flexclaims@groupresources.com
Work-life Balance through Unum	Employee Assistance Program	800-854-1446 www.lifebalance.net user ID & password: lifebalance
Assist America through Unum	Travel Assistance	Within the US: 800-872-1414 Outside the US: 609-986-1234 Email: medservices@assistamerica.com Reference number: 01-AA-UN-762490
Aflac	Optional Benefits	800-992-3522 www.aflac.com

Legal Notices

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your 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).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee's or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this packet.

Newborns' and Mothers' Health Protection Act Notice

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 child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or 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.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a postsecondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of:

- one year after the first day of a medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan.

A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

Legal Notices

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Disclosure about the Benefit Enrollment Communications

The benefit enrollment communications (the Benefit Guide, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Eastpointe Community Schools reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Legal Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer- sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA—Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website:
http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid:
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/ hipp.htm
Phone: 1-573-751-2005

Legal Notices

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid
Phone:1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone: 1-800-562-3022, ext.15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/ Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website:https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Telephone: 1-307-777-7531

Legal Notices

Creditable Coverage Notice
Important Notice from Eastpointe Community Schools About Your Prescription Drug Coverage and Medicare

IMPORTANT NOTE:
IF YOU (AND ALL OF YOUR DEPENDENTS) ARE NOT ELIGIBLE FOR MEDICARE,
YOU MAY DISREGARD THIS NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Eastpointe Community 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.
- Eastpointe Community Schools has determined that the prescription drug coverage offered by the Eastpointe Community Schools Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 through 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 Eastpointe Community Schools coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Eastpointe Community Schools coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

Legal Notices

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 Eastpointe Community Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below 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 Eastpointe Community Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	November, 2018
Name of Entity/Sender:	Eastpointe Community Schools
Contact—Position/Office:	Human Resources
Address:	24685 Kelly Road, Eastpointe, MI 48021
Phone Number:	586-533-3009

Glossary of Terms

MEDICAL

Approved Amount – The dollar amount BCBSM has agreed to pay for health care. Deductibles, copayments, and coinsurance are deducted from the approved amount.

BlueCard® – Program that gives you access to doctors and hospitals everywhere you travel. All BCBS licensees participate in this program.

COB – Coordination of benefits, a program that coordinates your health benefits when you have coverage under more than one group health plan.

Coinsurance – The percentage of the approved amount you must pay for eligible services once you have met your deductible. Coinsurance amounts may vary by type of service

Copayment – Amount you must pay the provider at the time of service.
This dollar amount does not accumulate toward your deductible or out-of-pocket maximum.

Deductible – The calendar year expense you incur before the plan or insurance carrier begins paying your covered expenses. Renews annually.

Durable Medical Equipment – Medically necessary equipment that can be used repeatedly (for example, wheelchair or respirator) to facilitate treatment and rehabilitation at home.

Eligible Dependents – A child (under the age of 26) who is your natural child, adopted, under your legal guardianship, placed with you for adoption, or a stepchild. Disabled children regardless of age if they are determined by a physician to be totally and permanently disabled by a physical or mental condition that began before age 19.

Emergency Medical Condition – An emergency medical condition is an illness, injury or symptom that requires immediate medical attention to avoid permanent damage, severe harm or loss of life.

Emergency Room Care – You are covered for the treatment of accidental injuries or a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately.

Explanation of Benefits (EOB) – A statement from the insurance carrier that details what services have been paid and what may be owed.

Lifetime Maximum – A specified dollar amount or a set number of services that the health plan will provide for each member on the contract.

Medically Necessary – A service must be medically necessary in order to be payable by your health care coverage.

Open Enrollment – A once-a-year opportunity, in the fall, to change your benefit elections for the next plan year. You can add or drop eligible dependents from coverage, and re- elect Health Care and Dependent Care Flexible Spending Account and Health Savings Account. (The only other opportunity you have to make changes is when you experience a Qualifying Life Event.)

Out-of-Pocket Maximum – The maximum amount you would pay in a calendar year for eligible medical expenses. Included in the amount are deductibles, co-insurance and co-pays (office visits and prescriptions).

Office Visit – A visit to a physician's office or outpatient clinic for the examination, diagnosis and treatment of a general medical conditions.
Services include medical care, consultations, medication and injections.

Primary Care Visit – (Non-Specialist) Visits include services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.

Routine and Preventive Visits – Office visits for Wellness and Routine Physical (services include Well Child Care, Immunization, Routine Gynecological Exam and Pap Smear, Mammogram, PSA Test and Related tests, [including colonoscopies after age 50]).

Specialist Office Visit – Office visits to physicians who are not family practitioners or primary care physicians and have a specialty, such as dermatology or podiatry.

Plan Year – January 1 through December 31. Each fall, you will make your selections for the following year.

Preapproval/Precertification – A process that allows you or your health care provider to know if BCBSM will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services, they will not be covered.

Preferred Provider Organizations (PPO) – An organization of participating providers who have agreed to provide their services at negotiated discount fees in exchange for prompt payment and increased patient volume. Enrollees may receive services outside the network, but at higher costs. The additional costs are usually in the form of higher deductibles and co-insurance.

Provider – A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

In-Network Participating Providers – Hospitals, physicians and other licensed facilities or health care professionals who

Glossary of Terms

have contracted with BCBSM to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept the BCBSM approved amount as payment in full for covered services.

Out-of-Network Participating Provider – This means a doctor or facility is not part of the PPO network, but agree to accept the BCBSM approved amount as payment. These providers will be covered at a lower coinsurance than in-network providers.

Out-of-Network Nonparticipating Providers – This means a doctor or facility is not part of the PPO network and services will not be covered or will be covered at a lower coinsurance than if your doctor were in the network. These providers do not agree to accept the BCBSM approved amounts and you may be responsible for the difference between the amount billed by the provider and the BCBSM approved amount.

Qualifying Life Event – Allows employees to make midyear election changes to their benefits when a change in status occurs. Events include change in marital status, change in number of eligible dependents, and change in employment status by you or your dependents.

Subscriber – The employee of Farmington Schools who is the primary policy holder.

Summary of Benefits and Coverage (SBC) – A standardized benefit summary required by Health Care Reform which outlines the medical and prescription drug coverage provided by an individual or group health plan. This summary allows for comparison of coverage across different types of health plans.

Urgent Care Centers – A center that focuses on diagnosing and treating conditions that aren't life-threatening yet they need to be taken care of right away. They offer quality care on a walk-in basis and have extended evening and weekend hours.

PRESCRIPTION DRUGS

Generic Drugs – Drugs whose active ingredients, safety, dosage, quality and strength are identical to that of its brand counterpart. These medications are covered at the generic copayment and typically cost less than brand drugs.

Preferred Drug List – A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the Blue Cross Blue Shield of Michigan Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.

Preferred Brand Drugs – Drugs which generally have no generic equivalent. These medications are covered at the brand copayment under the plan.

Non-Preferred Brand Drugs – Drugs which generally have equally effective and less costly generic equivalents and/or have one or more formulary- brand options. A BCBSM HealthCare member or his/her provider may decide that a medication in this category is best. These medications are usually covered at the highest copay.

Mail Order – A program that allows you to order a 90 day supply of your maintenance medications through the mail or online and have them mailed directly to you.

Prior Authorization – A cost-saving feature that helps ensure the appropriate use of selected prescription drugs. This program is designed to prevent improper prescribing or use of certain drugs that may not be the best choice for a health condition.

Retail 90 – Is an alternative to mail order that allows you to get a three- month supply of maintenance drugs from a retail pharmacy that participates in the retail 90 program.

Specialty Drugs – Drugs used to treat complex conditions that require special handling, administrator or monitoring. These drugs treat complex and chronic conditions, including:

- Cancer
- Chronic kidney failure
- Multiple sclerosis
- Organ transplants
- Rheumatoid arthritis

Step Therapy – In pharmaceuticals, process of treating a patient with the least intrusive medication or therapy initially, then graduating to more complex medications or therapies, if required.

Glossary of Terms

DENTAL

Basic Services – These services include restorations (fillings), oral surgery (extractions), endodontics (root canals), and periodontal treatment (root planing).

Calendar Year Maximum – A specified dollar amount that the dental plan will provide for each member on the contract per calendar year.

Diagnostic & Preventive – Services and procedure to determine your dental health or to prevent or reduce dental disease. These services include examinations, evaluations, prophylaxes (cleanings), x-rays, space maintainers and fluoride treatments.

EOB – See Medical

Major Services – Artificial devices to restore natural teeth or treat diseases of the gum and tissues around the teeth.

Pre-Treatment Estimate of Benefits – When the charges from a dentist for a proposed course of treatment are expected to be over $250, a pre- treatment estimate of benefits is strongly recommended before any services are performed.

You or your dentist can mail information to carrier for a pre-treatment estimate of benefits. The carrier will provide information on the portion of the charges that will be covered.

FLEXIBLE SPENDING ACCOUNTS (FSA)

An FSA Account is a great option for reducing your taxes as well as setting aside funds to cover health and dependent care expenses. With this account, you contribute money from your paycheck each period, before taxes, and you can use that money to pay for certain health care and daycare costs.

Health Care Reimbursement Account (HCRA) – Allows the use of pre-tax dollars to pay out-of-pocket health care expenses not covered by your medical, dental and vision plans.

Dependent Care Reimbursement Account (DCRA) – Allows the use of pre-tax dollars to pay dependent care expenses including the costs for a daycare center, a baby-sitter or other caregiver for a dependent or a disabled spouse or parent.

FSA Debit Card – Provides participants easy access to their Flexible Spending Accounts through an electronic payment option. At the time of purchase, transactions using the FSA debit card are charged against your personal FSA balance.

Eligible Dependent Care Expenses – Payments for daycare in your home or at a daycare facility that complies with all licensing requirements or is exempt from such requirements.

Preschool care, before and after school care and day camp during school vacations. A complete list is available in the IRS Publication 503.

Eligible Health Care Expenses – Payments include those that would qualify for a deduction on your federal income tax return. A complete list is available in the IRS Publication 502.

Use-it-or-Lose-it – Any balance in the Health Care or Dependent Care Spending Accounts that is not used for eligible expenses within the plan year will be forfeited.

Substantiate – The Internal Revenue Service requires substantiation of purchases by presenting supporting documentation (e.g. receipt, EOB) when the eligibility of the purchase cannot otherwise be verified. The process is very simple. Most claims will require substantiation.

Notes

EASTPOINTE
COMMUNITY SCHOOLS

2019 Benefit Guide

EFE

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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