ROCHESTER
COMMUNITY SCHOOLS

PRIDE IN EXCELLENCE

SECRETARIES

2021 Benefit Guide

ROCHESTER
COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

Department of Human Resources

501 W. University Drive Rochester, MI 48307

Phone: 248-726-3000 Fax: 248-726-3187

Welcome to Rochester Community Schools!

Rochester Community Schools will provide you with *a **District Employee Number (DEN)***. Your DEN is your identification for the District. This will be created when your employment information is entered into our system. If you have questions about your DEN, please contact the Payroll Department.

An **email account** will also be created at the time employment information is added into our system. The standard format for email accounts is first initial-last name.rochester.k12.mi.us (i.e., asmith@rochester.k12.mi.us). Once the DEN and email address is created, the information will be sent to your building secretary.

You will not receive a paper copy of your paystub. Your *payroll information* is available through ***Employee Online***.

The ***Human Resources Department*** is located on the third floor of the district's Administration Center. Our *website* is full of valuable, up-to-date information. As a new employee, please visit our webpage for documentation regarding your employment with Rochester Community Schools and/or general information on the following:

- Yearly Working Calendars
- Employee Contracts
- Frequently Used Forms
- Teacher Professional Development and Certification Renewal Information
- Your Benefit Guide and related documentation, including Life Insurance and Long Term Disability
- Leave of Absence Information
- Employee Injury Reporting
- Frontline Education, KALPA, Professional Growth Directions and Manuals

To access our website please go to:

www.rochester.k12.mi.us

Click on the District Info > Human Resources

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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.

Important Information

This Guide will give you an overview of the benefit plans we sponsor. You will need to make decisions about your 2021 benefit elections.

Enrollment

Each year in the fall, you have the opportunity to review or make changes to your current elections during the open enrollment period. Human Resources will communicate any plan changes, rates, and provide instructions on how to make changes to your benefits during this time. Changes made during Open Enrollment will be effective January 1.

Open Enrollment

During this period you may add, drop, or modify coverage. You will be locked into the plan selections from January 1 through December 31, unless there is a qualifying change in status event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event.

New Hire Enrollment

Initial Enrollment in Rochester Community Schools benefit plans must be completed by the date established in your new hire orientation, and no later than 30 calendar days from date of employment. Once you make your elections, coverage will remain in effect through the end of the plan year, December 31, unless you have a qualified change in status event. If you do not experience a change in status event, you must wait until the next annual open enrollment period to make changes.

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 (generally during open enrollment)—January 1 through 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.

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.

Eligibility

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 Rochester Community Schools' medical plan to ensure that you meet your individual mandate and avoid the IRS tax.

Eligible Employees

You are eligible for coverage under the Plan after 60 days of employment if you are regularly scheduled to work six (6) hours or more per day.

In accordance to your contract, you cannot have double coverage, which means you cannot be covered by this policy and a second policy. Coverage by two polices will deem you ineligible for one year.

Should you terminate employment with the District, your benefits will end on the date of your termination.

Eligible Dependents

As you become eligible for these benefits, so do your eligible dependents. Eligible dependents are:

- Your legally married spouse.
- Your children until the end of the month they reach age twenty-six (26), including adopted, step-children, and children acquired through legal guardianship.
- Disabled children who are dependent on you for support, reside with you and cannot work to support himself or herself. You can continue that child's coverage beyond age twenty-six (26), as long as you remain eligible. You must submit proof that your child is fully disabled within thirty (30) days after your child's coverage would otherwise end.

Dependent Eligibility Rules and Documentation Requirements

All employees who cover a spouse and/or child(ren) on the District's benefit program must provide documentation of dependent eligibility. If adding a new dependent to the plan, you must provide copies of the necessary documentation to verify the dependents you enroll for medical, dental, and vision coverage are eligible.

Spouse—A copy of the marriage license.

Child under age 26—A copy of the birth certificate, adoption papers or court guardianship document.

Child over age 26—The required documentation for a child listed above, and any documentation verifying a permanent disability that began before the child turned 26.

Employee Contributions

Listed below are the 2021 Medical Coverage Per Pay Premiums for employees. **There is no charge for dental or vision coverage.**

	BCBSM PPO Plan			BCBSM High Deductible Plan		
	Employee	**Employee + One**	**Family**	**Employee**	**Employee + One**	**Family**
26 Pay Periods	$58.31	$139.93	$174.91	$52.26	$123.27	$151.40
21 Pay Periods	$72.19	$173.25	$216.56	$64.70	$152.62	$187.45

Opt-Out Incentive

If you choose to decline medical coverage, your opt-out incentives are shown in the table below. The opt-out cash incentive will be distributed as taxable income. If you choose to decline medical coverage, you must complete and sign the Opt-Out Attestation of Other Coverage on the Enrollment Form.

Opt-Out Incentive	
Monthly Cash Option	**Additional Life and AD&D**
$125	$50,000

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.

Medical

Rochester Community Schools offers the following medical plan options:

- Blue Cross Blue Shield of Michigan — PPO
- Blue Cross Blue Shield of Michigan — PPO High Deductible Health Plan **(HDHP)** with a Health Savings Account **(HSA)**
- Opt-Out

The Blue Cross Blue Shield of Michigan medical plans are "self-funded". This means that each medical claim is paid directly by Rochester 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, Rochester 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.

About Your Plans

"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 www.bcbsm.com. 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 and your dependents are covered under another group medical and prescription drug plan, you may be eligible for the **Opt-Out** bonus. This taxable bonus is paid annually during the month of December in lieu of medical and prescription drug coverage. To be eligible to receive this bonus, you must complete the attestation acknowledgement on the Benefit Election Form.

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

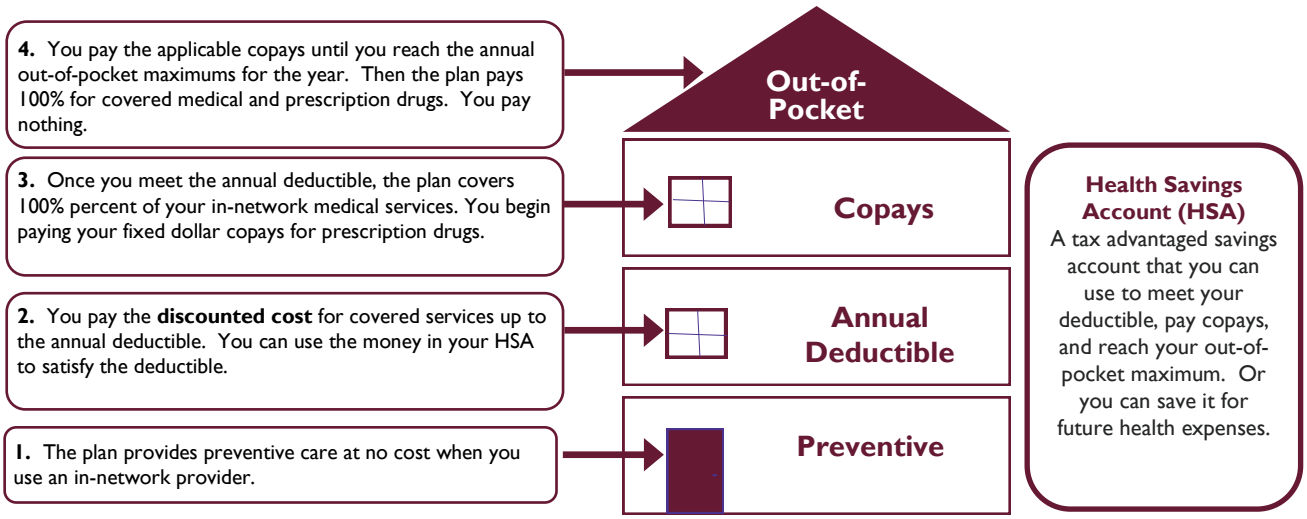
High Deductible Health Plans (PPO) with a Health Savings Account

The **High Deductible Health Plan (HDHP)** works much like our other PPO Plans. A *high deductible health plan* pairs a high-deductible, lower premium health plan with a tax-free **Health Savings Account (HSA)** that reimburses you for current and future medical expenses. All services, including prescriptions and office visits are subject to the annual deductible with the exception of certain preventive care services. Preventive care services are covered at 100% with no deductible when performed by a in-network provider.

HealthEquity® is the administrator of the Health Savings Account (HSA) with the BCBSM HDHP. An HSA is an interest bearing account that enables you to pay for current health care expenses with tax-free money (such as deductible and coinsurance) or to save for future health care expenses. It is designed to follow you into retirement. Therefore, money rolls over year after year and earns interest.

It's important to note that the annual deductible under the HDHP works differently than the PPO Plan. Under the HDHP two person or family coverage, benefits for an individual will be payable only when the **FULL** family HDHP deductible has been met. That means that services for an individual are not covered after they have satisfied the individual deductible as they are under the other PPO plan.

How the High Deductible Health Plan Works



For more info on HSA, go to www.healthequity.com or direct to the IRS website for Publication 969

Medical Plans

Health Savings Account

- Health Savings Accounts (HSA) are **only** available to employees enrolled in the High Deductible Health Plan (HDHP). To be eligible to contribute to an HSA, you cannot be covered by another health plan. This includes a Flexible Spending Account, Medicare or any health plan that does not qualify as a "high deductible health plan". You must not have received VA benefits for non-service related care, or non-preventive Indian Health Services at any time over the past three months. Lastly, you cannot be claimed as a tax dependent by anyone else.
- You can use the money in your HSA to pay for medical expenses for yourself, your spouse and tax dependents even if they are not covered under the HDHP. With an HSA, you do not have to submit a claim with receipts. Instead, you simply request a reimbursement (just like a bank account) or use the debit card to pay for medical expenses.
- **The maximum annual contributions for 2021 are $3,600 for single coverage and $7,200 for family coverage.**
- Individuals age 55 or older (and not enrolled in Medicare) may contribute an additional amount referred to as a catch-up contribution. The maximum annual catch-up contribution is $1,000.

Top Reasons to Enroll in an HSA

- HSAs triple your savings.
- Contributions are not taxed.
- Your earnings and growth are not taxed.
- Reimbursements to pay for medical care are tax free too
- The money in your account is accessible. You will receive a debit card, and by swiping the card at your doctor's office or pharmacy, you withdraw money from your account. Or you can request a disbursement from your HSA.
- There's no "use it or lose it" rule. HSAs are designed to follow you into retirement. Therefore, the money rolls over year after year.
- Like your 401(k), HSAs grow with time. You earn interest on the money in your HSA, and better yet, can invest amounts over $2,000 in mutual funds.
- You own it. You control it. No matter where you go or what you do, you can take your HSA with you.

Prorated HSA Contributions for Mid-Year Changes and Enrollments

If you are covered by a HDHP for only part of the 2021 calendar year, your contribution limits are prorated according to the number of months you are covered by a HDHP on the first day of the month.

If you are new in a HDHP and your first day in the HDHP is other than January 1, 2021 the IRS still allows you to contribute up to the annual maximum contribution for that year.

However, you must still be covered under the HDHP on December 1st of that same calendar year (2021), as well as all 12 months of the following calendar year—2022.

If you are not enrolled the entire 2021 calendar year, the IRS makes you pay tax on the extra contributions you made based upon the months you weren't enrolled in the HDHP, plus a 10% penalty on those excess contributions.

Medical, continued

	BCBSM—PPO		BCBSM– HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Copay Services				
Preventive Care Visit (One per member per year)	100%	Not Covered	100%**	Not Covered
Office Visits	$20	30% after deductible	Most services subject to deductible and coinsurance	
Urgent Care	$20	30% after deductible		
Emergency Room (waived if admitted)	$250	$250		
Urgent Care	$20	30% after deductible		
In-Network Prescription Drug Copays				
Generics	$5		$10 copay after deductible	
Preferred Brand	$35		$40 copay after deductible	
Non-Preferred Brand	$50		$80 copay after deductible	
90 Day Supply- Mail Order	2x copay		2x copay after deductible	
Deductible, Coinsurance, and Out-of-Pocket Maximum				
Deductible - per calendar year	$500 individual $1,000 family	$1,000 individual $2,000 family	$1,400 individual $2,800 family	$2,800 individual $5,600 family
			The full family deductible must be met under a two–person or family contract before benefits are paid.	
Annual Employer Funding to HSA	None		$700 for individual $1,400 for family	
Coinsurance Amounts (Percentage)	Plan Pays 90% Member Pays 10% (most services)	Plan Pays 70% Member Pays 30% (most services)	Plan pays 100% Member pays 0% *After deductible	Plan pays 80% Member pays 20% *After deductible
Coinsurance Maximum (per calendar year)	$1,000 individual $2,000 family	$2,000 individual $4,000 family	None	None
Annual Out-of-Pocket Maximum *Includes deductible, flat-dollar copays (medical and prescription) and coinsurance combined. Once met, plan pays 100% for all services.*	$4,000 individual $8,000 family	$8,000 individual $16,000 family	$2,250 individual $4,500 family	$4,500 individual $9,000 family

For detailed coverage information please refer to the BCBS Benefit At A Glance documents on the RCS website

Prescription Drugs

Specialty Drugs

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 asthma, cancer, multiple sclerosis, rheumatoid arthritis, Hepatitis, Chronic Kidney Failure and other conditions. A list of specialty drugs is available online at bcbsm.com. If your medication is included in the **Specialty Drug Guide** you can:

- Get your prescription drugs delivered to your home by mail ordering them through Walgreens Specialty Pharmacy (formerly known as Option Care), our specialty drug vendor. Download the Specialty Drug Brochure for ordering instructions, or call Walgreens Specialty Pharmacy at 1-866-515-1355 to order.
- Fill your prescription at a retail pharmacy. Not all pharmacies will dispense specialty drugs, so call your pharmacy to verify that they will fill your prescription.
- If filling your prescription at a retail pharmacy outside of Michigan, you must make sure the pharmacy you will be using participates in the out-of-state specialty pharmacy network.

Specialty drugs are only available in a 30 calendar day supply, whether you choose to fill them at a retail pharmacy or through mail order. BCBSM may limit the initial quantity of select specialty drugs (15 calendar days). Your copay will be reduced by one-half for this initial fill.

Mandatory Generic Program

The mandatory generic program requires that prescriptions be filled with a generic product, if available.

- If your doctor writes a prescription for a brand name drug when a generic alternative is available, the pharmacy will dispense the generic drug and you will pay the generic copay.
- If you request the brand name drug, you will pay the brand name copay and the cost difference between the brand name and generic drugs.
- If the doctor writes “Dispense as Written (DAW)” on the prescription, the pharmacy will dispense the brand name drug and you will pay the brand name copay and the cost difference between the brand name and generic drugs.
- If your doctor deems it medically necessary for you to take the brand-name version of a drug with a generic equivalent, they can contact the Blue Cross Blue Shield Clinical Help Desk to seek approval to waive the added cost. Your doctor will be the one who initiates the approval process and they should be familiar with how to do so.

Dental

We offer a Blue Dental PPO Plus plan to employees. The dental plan is administered by Blue Cross Blue Shield of Michigan (BCBSM). Rochester Community Schools pays the full cost for dental coverage.

You may go to any licensed dentist but you could increase your benefits and lower your out-of-pocket cost by up to 40% by going to a Blue Dental PPO dentist. Simply notify the dentist that you have Blue Cross Blue Shield dental coverage and in most cases, they will submit all claims and only bill you for any balances due.

Blue Dental PPO is the national, dental Preferred Provider Organization (PPO) network for Blue Cross Blue Shield of Michigan with over 190,930 dentists in the national network. This means that you can visit any participating dentist on the list of Blue Dental PPO dentists and save on your dental costs. Blue Dental PPO is a group of quality dentists who have agreed to accept a set, discounted fee schedule for Blue Dental PPO members.

Members can receive an additional discount for non-covered benefits (including orthodontia) or for covered benefits after the annual maximum has been met. When members seek services from a Blue Dental PPO provider, the provider will charge a reduced fee using pre-negotiated discounts. The member will pay the provider directly. Orthodontic services from a Blue Dental PPO provider will only be charged the Blue Dental PPO fee, not the provider's full charge.

Please Note: You will use your Blue Cross Blue Shield ID Card as your dental card.

Plan Year: Calendar Year-January 1 through December 31	In-Network	Out-of-Network
Maximum Benefits		
Individual Deductibles (per calendar year)	None	None
Individual Annual Maximum for Classes I, II and III Services	$1,600	$1,600
Individual Lifetime Maximum for Class IV Services	$1,700	$1,700
Class I—Preventive Services	100% covered	100% covered
Class II—Restorative Services	80% covered	80% covered
Class III—Major Services	60% covered	60% covered
Class IV—Orthodontic Services	60% covered	60% covered
Important Notes • Members who go to nonparticipating dentists are responsible for any difference between BCBSM approved amount and the dentist's charges. • For non-urgent, complex or expensive dental treatment such as crowns, bridges, or dentures, members should encourage their dentist to submit the claim to BCBSM for predetermination before treatment begins.		

For detailed coverage information please refer to the BCBS Benefit At A Glance documents on the RCS website

Vision

Your vision benefit is administered by **Heritage Total Services**, an independent company that provides vision benefits for Blue Cross Blue Shield of Michigan (BCBSM) members. Rochester Community Schools pays the full cost for vision coverage.

Please Note: You will use your Blue Cross Blue Shield ID Card as your vision ID card.

To find a Heritage Total Services provider call **1-866-852-8947** or visit http://www.heritagevisionplans.com/.

No Claim Form Needed! When visiting an out of network provider, pay the full charge and request an itemized receipt with the following information:

- *Employee's name and mailing address*
- *BCBSM de-identified contract number*
- *Employer*
- *Patient's name, date of birth and relationship to the employee*
- *Service date*
- *Services and/or materials received*
- *Type of lenses received (i.e., single vision, bifocal, trifocal or contact lenses)*

Simply mail the itemized receipt to:
Heritage Vision Plans, Inc.
One Woodward Avenue, Suite 2020
Detroit, MI 48226
or email: eligibility@heritagevisionplans.com

	In-Network	Out-of-Network
Eye Exam—Once every 12 consecutive months	$5 copay	Reimbursement up to $35 less $5 copay*
Lenses and Frames—in lieu of contact lenses once every 12 consecutive months		
Standard Lenses (with or without frames)	$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type after $7.50 copay*
Standard Frames	$130 allowance applied toward frame, less $7.50 copay Member responsible for any cost exceeding the allowance	Reimbursement up to $45 after $7.50 copay*
Contact Lenses—in lieu of lenses/frames once every 12 consecutive months		
Medically Necessary—Requires prior authorization approval from Heritage and must meet criteria of medically necessary.	$7.50 copay	Reimbursed up to approved amount less $7.50 copay*
Elective—contact lenses are covered up to allowance every 12 consecutive months	$35 allowance applied toward contact lens exam and contact lenses*	$35 allowance applied toward contact lens exam and contact lenses*
*member responsible for any difference		

Flexible Spending Accounts

Flexible spending accounts (FSAs) provide a way to pay for qualified health care and dependent care expenses with pre-tax dollars. There are two types of accounts available: a Health Care Reimbursement Account (HCRA) and a Dependent Care Reimbursement Account (DCRA), which are administered by **BASIC**. You may enroll in one or both of these accounts each year.

How Do Flexible Spending Accounts Work?

You decide on an amount that will cover your expected out-of-pocket health and/or dependent care expenses during the plan year, which runs from January 1 through December 31. The total amount you elect will be deducted in equal amounts, on a pre-tax basis, from the number of paychecks you receive during the plan year.

When you use your FSA debit card to pay for an eligible health care expense, the claim is paid immediately from your HCRA with pre-tax dollars. Similarly, if you pay out-of-pocket for an eligible expense and then submit a claim form for reimbursement, your reimbursement is not taxed. A list of eligible expenses can be found in IRS Publication 502 at www.irs.gov.

Please note: If you contribute to a DCRA, you must file IRS Form 2441 with your federal income tax return. Form 2441 is simply an informational form on which you report the amount you paid, and who you paid, for dependent care services.

	HCRA	DCRA
Account Purpose	To pay for eligible medical, prescription drug, dental, vision and hearing expenses not covered by another health plan.	To pay for eligible child care and dependent care expenses that allow you (and your spouse, if applicable) to work or attend school full-time
Maximum Annual Contribution per Plan Year *(January 1—December 31)*	$2,750	$5,000, or $2,500 if married and filing separate tax returns
Access to Funds	You have immediate access to your entire HCRA election as of January 1. You may be reimbursed up to your annual election amount at any point during the plan year, even if you have not yet contributed that amount to your FSA via payroll deductions.	You can only be reimbursed up to the balance you currently have in your DCRA.
Examples of ELIGIBLE Expenses	◆ Deductible and coinsurance amounts ◆ Office visit and ER copayments ◆ Prescription drug copayments ◆ Hearing aids ◆ Dental treatment and orthodontia ◆ Eyeglasses and contact lenses ◆ Contact lens cleaning supplies ◆ Laser vision correction surgery	◆ After-school care ◆ Child daycare center ◆ Day camp ◆ Elder care ◆ In-home care (such as a nanny or babysitter)

Flexible Spending Accounts, continued

	HCRA	DCRA
Examples of INELIGIBLE Expenses	◆ **Over-the-counter drugs for which you do not have a prescription** ◆ Vitamin supplements and herbal remedies ◆ Cosmetic surgery and procedures ◆ Teeth bleaching/whitening ◆ Gym/health club dues ◆ Diapers/diaper service ◆ Insurance premiums	◆ Overnight camp ◆ Music lessons ◆ Nursing home ◆ Amounts paid to your spouse, or to your dependent child under age 19 ◆ Expenses for future services
Debit Card	Use your VISA debit card to pay for eligible health items and services at the point of sale. This card can be used only at eligible locations where it is accepted. This may include medical and dental providers, pharmacies and vision centers. It also includes stores, such as Target, CVS and Wal-Mart, which have an IRS-approved inventory system in place that can identify FSA-qualified items. BASIC may ask you to provide substantiation whenever you use the debit card. Please keep all documentation related to your FSA claims, such as itemized receipts and Explanations of Benefits from BCBSM. If you do not respond back to BASIC's request in a timely manner, your debit card will be suspended from use until you either provide substantiation or repay the debited amount.	The debit card is not available for use with this account. You must submit manual claims for reimbursement from your DCRA.
Manual Reimbursement of FSA Claims	Submit within the **Online Portal Website**: Go to the Online Portal Website (www.cda.basiconline.com) and login. Please remember your submission is not considered a claim until the required documentation is received. Claims need to be submitted prior to your plans final filing date (filing deadlines apply). **You will be reimbursed via direct deposit (you must sign up for direct deposit separately).** Please obtain a direct deposit form from HR to set up direct deposit.	Submit within the **Online Portal Website**: Go to the Online Portal Website (www.cda.basiconline.com) and login. Please remember your submission is not considered a claim until the required documentation is received claims need to be submitted prior to your plans final filing date (filing deadlines apply). **You will be reimbursed via direct deposit (you must sign up for direct deposit separately).** Please obtain a direct deposit form from HR to set up direct deposit.
Grace Period	For the 2021 plan year—Claims may be incurred until March 15, 2022 for reimbursement under the 2021 Plan Year.	For the 2021 plan year—Claims may be incurred until March 15, 2022 for reimbursement under the 2021 Plan Year.

Flexible Spending Accounts, continued

Use this worksheet to estimate your annual expenses for health care and/or dependent care. Your actual expenses this year may be a good indication of next year's expenses. Eliminate those expenses that will not reoccur and add new expenses you know will happen.

Consider differences in your medical plan provisions, such as co-pays and deductibles, between your current plan and the plan you selected for next year.

Flexible spending accounts Worksheet	**Past 12 Months**	**Next Year's Projected Expenses**
Medical Expenses—*These include, but are not limited to, the following types of medical care expenses incurred by you and/or your eligible dependents:*		
Medical care expenses (not covered by your insurance plan)	$	$
Chiropractor Fees	$	$
Copayments (that flat dollar amount required for each office visit)	$	$
Coinsurance (your share of covered medical expenses after you meet deductible requirements)	$	$
Deductible Requirement	$	$
Drug and chemical dependency treatment (including smoking cessation programs when accompanied by prescription or letter of medical necessity)	$	$
Immunizations	$	$
Laboratory Fees	$	$
Mileage/Transportation	$	$
OTC Drugs (with a prescription or letter of medical necessity)	$	$
Prescription Drugs	$	$
Psychiatric/Psychologist Fees	$	$
Well-Child Care	$	$
X-Ray Fees	$	$
Dental Expenses—*These include, but are not limited to, the following types of dental care expenses incurred by you and/or your eligible dependents:*		
Coinsurance (your share of covered dental expenses after you meet deductible)	$	$
Deductible Requirement	$	$
Dental Exams	$	$
Filling/Bridges/Restorations	$	$
Orthodontia Treatment	$	$
X-Ray Fees	$	$
Other	$	$
Vision Expenses—*These include, but are not limited to, the following types of vision care expenses incurred by you and/or your eligible dependents:*		
Contact Lens Solution & Cleaners	$	$
Copayment	$	$
Corrective Eye Surgery	$	$
Eye Exams	$	$
Frames, Prescription Lenses, Contact Lenses and/or Prescription Sunglasses	$	$
Total Estimated Expenses for Next Plan Year	**$**	**$**

Life/AD&D

Dearborn National

Basic Life/AD&D

The District provides a Basic Life and AD&D benefit of $45,000 to employees working 30+ hours per week. If you opt-out of Medical coverage through the District, you will receive an additional Life and AD&D benefit of $50,000 (for a total of $95,000 of coverage). Rochester Community Schools pays the full cost for this coverage. Accidental Death and Dismemberment (AD&D) insurance pays an additional benefit if your death is a result of an accident. You may also receive a portion of the benefit for other losses (limb, eyesight, etc.) if the loss is a direct result of an accident.

Your coverage is insured by **Dearborn National**.

Benefits reduce based on age and terminate at retirement. Coverage effective dates and increases in coverage may be delayed if someone is disabled on the date coverage is scheduled to take effect. Review the carrier booklet for details.

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.

Optional Life/AD&D

We offer employees and their dependents the opportunity to purchase Life/AD&D coverage above and beyond what is provided by the District. Optional Life/AD&D coverage is also insured by **Dearborn National**.

Evidence of insurability is required for coverage above the Guarantee Issue Amounts listed in the chart below. It is also required if you waive coverage when you are initially eligible, and choose to enroll at a later date; or you apply to increase your coverage during open enrollment.

Benefits reduce based on age and terminate at retirement. Coverage effective dates and increases in coverage may be delayed if someone is disabled on the date coverage is scheduled to take effect. Review the carrier booklet for details.

*You must participate in order to elect coverage for your spouse. Spouse coverage is limited to spouses under age 70. Once a spouse reaches age 70, any Optional Life/AD&D coverage will terminate.

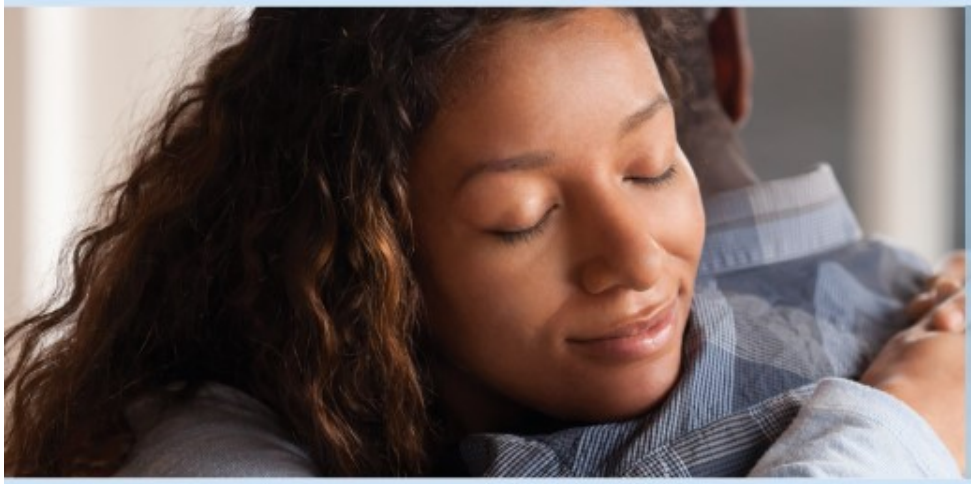
Employee	$10,000 increments up to the lesser of five (5) times your annual salary or $500,000 Guarantee Issue Amount: up to the lesser of two (2) times your annual salary or $100,000
Spouse *	$10,000 increments up to the lesser of 50% of the employee amount or $150,000 Guarantee Issue Amount: $20,000
Children	$2,500 increments up to a maximum of $10,000 Guarantee Issue Amount: $10,000

Notice of Continuation Rights

In the event your Life and AD&D insurance coverage ends, you have 31 days from that date to apply for continuation of that coverage, so you may maintain some level of benefit by paying the premium directly to the carrier.

Please refer to the Life and AD&D benefit books, for additional information and instructions on how to apply for continuation. Depending on your situation, you may not be eligible for all continuation options. It is also possible that your premium for coverage continuation will be different from what you pay as an employee of Rochester Schools.

Additional Services



Beneficiary Resource Services™

Benefits Beyond a Check

When a loved one dies, families often face complex issues ranging from estate planning, legal questions, funeral planning and coping with grief and financial uncertainties. That's why we offer Beneficiary Resource Services, a program that combines family wellness and security at the most difficult of times. Services include grief and financial counseling, funeral planning, legal support and online will preparation. Beneficiary Resource Services is provided by Morneau Shepell.

Beneficiary Resource Services™

Counseling:
800-769-9187

BeneficiaryResource.com
Username: beneficiary

Dearborn Group™

Services for Insureds and Their Families

Online Will Preparation

You and your family have access to a full legal library with many estate planning documents, including an online will. You can create your own will online in a safe and secure way, right from your home. The will can be saved and updated as family situations change. Creating a will provides security and peace of mind for several reasons:

- Appoints a guardian for children
- Controls where property and assets go
- Provides family security

Online Funeral Planning

You have access to an online funeral planning site that features a variety of helpful tools and information, such as:

- A downloadable funeral planning guide to document vital information your loved ones will need when making final arrangements
- Calculators to estimate and compare expenses for various types of funeral arrangements
- Information on funeral requirements and various religious customs
- Directories to locate funeral homes and cemeteries in your area

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Additional Services, continued

Travel Resource Services™

Your Ticket to Safe and Worry-Free Travel

Our Travel Resource Services provider, Generali Global Assistance, Inc. (GGA), offers around-the-clock emergency and information services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Help is there when a crisis strikes. More than 850,000 multilingual service professionals stand ready to assist you in more than 200 countries and territories worldwide.

In 2017, almost

72 million

U.S. citizens traveled outside the country.[1]

Travel Resource Services™

In the U.S. and Canada, call

877-715-2593

From other locations (call collect)
202-659-7807

ops@us.generaliglobalassistance.com

Key Services

Medical Search and Referral: GGA will assist you in finding physicians, dentists and medical facilities.

Medical Monitoring: During the course of a medical emergency, professional case managers, including physicians and nurses, will monitor your case to determine whether the care is appropriate or if evacuation/repatriation is required.

Medical Evacuation/Return Home: In the event of a medical emergency, when a physician designated by GGA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, GGA will arrange and pay for the transport under proper medical supervision.

Traveling Companion Assistance: If a travel companion loses previously made travel arrangements due to your medical emergency, GGA will arrange for your traveling companion's return home.

Dependent Children Assistance: If any qualifying dependent children under the age of 18 traveling with you are left unattended because you are hospitalized, GGA will arrange and pay for their economy class transportation home. Should transportation with an attendant be necessary, GGA will arrange for a qualified escort to accompany the children.

Visit by Family Member/Friend: If you are traveling alone and must be or are likely to be hospitalized for at least seven consecutive days or in critical condition, GGA will arrange and pay for round-trip transportation for one member of your immediate family, or one friend designated by you, from his or her home to the place where you are hospitalized.

Return of Mortal Remains: In the event of your death while traveling, GGA will arrange and pay for all necessary government authorization, including a container appropriate for transportation and for the return of the remains to the place of residence for burial.

To Access Your Services, call

877-715-2593
In the U.S. and Canada

202-659-7807 from other locations

Sick Bank & Disability

Sick Bank

The first thirty (30) work days of illness or disability will not be covered by the Bank, but must be covered by the member's own accumulated sick leave or absence without pay.

The thirty (30) work day qualifier will only be required for the first occurrence of the same illness or disability within a two (2) year period of time.

If a member has more than forty (40) days in his/her personal sick bank, he/she must use all personal bank days down to forty (40) days before entering the sick bank.

While drawing sick leave benefits, a member cannot be receiving any other pay from the Board.

A maximum of two hundred ten (210) days in a two (2) year period of time can be drawn by a member who is a twelve (12) month employee from the Bank. A less than twelve (12) month employee may draw a maximum of one hundred eighty (180) days in a two (2) year period of time from the Bank.

The Bank will be controlled by a committee composed of two (2) Association members selected by the Association, and two (2) administrators selected by the Superintendent, but final authority in regards to the interpretation of this policy will rest with the Board.

A member drawing from the Bank will receive eighty percent (80%) of his/her regularly hourly rate.

Long-Term Disability

We offer a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. Rochester Community Schools pays the full cost for this coverage. This coverage is insured by **Dearborn National.**

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Please review the carrier booklet for details.

Item	LTD Benefit
Monthly Benefit	66.67% of earnings to a monthly maximum of $2,600
Elimination Period	364 days
Benefit Period	Benefits are payable up to normal Social Security retirement age. Benefits are limited to 24 months in a person's lifetime for mental illness conditions and self-reported symptoms unless you are confined to a hospital.
Definition of Disability	Disability is the inability to perform the substantial duties of your regular occupation due to injury or sickness during the elimination period and the next 24 months. After this period, it is the inability to perform the substantial duties of *any* occupation which you are qualified by education, training or experience.
Pre-existing Conditions	Benefits aren't payable for a disability that is caused by, or contributed to by a pre-existing condition, if the disability starts before the end of your first twelve months of coverage. A sickness or injury is pre-existing if, during the three months before your coverage effective date, you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines.

Rochester Community Schools

Are you aware of your 403(b) benefit?

THE OPPORTUNITY

You have the opportunity to save for retirement by participating in your Employer's 403(b) retirement plan. A 403(b) plan is a retirement plan for certain employees of public schools, tax-exempt organizations and ministers.

WHY SAVE WITH 403(b)?

> You do not pay income tax on allowable contributions until you begin making withdrawals from the plan, usually after your retirement.

> Investment gains in the plan are not taxed until distributed.

> Retirement assets can be carried from one employer to another in most cases.

Sample: Future retirement savings value assuming 6% yield on invest.**

Monthly Contributions	5 Years	15 Years	20 Years
$50	$3,489	$14,541	$23,102
$200	$13,954	$58,164	$92,408
$500	$34,885	$145,409	$231,020

HOW CAN I PARTICIPATE?

Prior to contributing you must open an account with an investment provider participating in the Plan, a list of which is available on the right. Click the link below to print and complete a Salary Reduction Agreement:

https://www.omni403b.com/spinforeq.aspx?org=752

Submit this form to your business office.

HOW MUCH CAN I CONTRIBUTE ANNUALLY?

You may contribute up to $19,500 in 2020. For appropriate limits for your particular circumstances, please contact OMNI's Customer Care Center at 877-544-6664.

Contribution Limits		15 Yr. Service Catch-up (if eligible)	Maximum Employer Contributions	Combined Limit	
Age 49 & below	Age 50 & above			Age 49 & below	Age 50 & above
$19,500.00	$26,000.00	$29,000.00	$57,000.00	$57,000.00	$63,500.00

Looking for Help?

Click the link below for an investment professional to reach out to you.

https://www.omni403b.com/PlanDetail.aspx?tml=752

New accounts may be opened with following approved service providers

AIG RETIREMENT SERVICES (FORMERLY VALIC)
AMERICAN FUNDS SERVICE COMPANY
AMERIPRISE FINANCIAL/RIVERSOURCE
DIVERSIFIED INVESTMENT ADVISORS
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY (FORMERLY AXA)
FIDUCIARY TRUST INTL-FRANKLIN TEMPLETON
INVESCO OPPENHEIMERFUNDS
LINCOLN INVESTMENT PLANNING
LINCOLN NATIONAL
LPL FINANCIAL CORPORATION
METLIFE
ORION PORTFOLIO SOLUTIONS LLC (FORMERLY FTJ FUND-CHOICE)
PARADIGM EQUITIES INC.
PUTNAM INVESTMENTS
AIG RETIREMENT SERVICES (FORMERLY VALIC) - 457
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY (FORMERLY AXA) - 457
METLIFE - 457

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. This program is provided by **HelpNet** at no cost to you! When you or your family members need helpful guidance, counseling, local resources or reliable professional care, the EAP program is just a phone call or click away. Services are available on a live basis 24/7, 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:

- **Legal consultation**—support with personal legal concerns
- **Parenting**—receive guidance on child development, sibling rivalry, separation anxiety and much more
- **Child Care/Elder Care**—find a place that's right for you and your family
- **Education & Schooling**—Learn about college testing, admissions, financial aid and advice to help your child get admitted to the school they want to attend.
- **Online resources** —access to extensive content to help with personal or family concerns, retirement planning tools and more.

Your program includes brief counseling sessions. However, for problems that require more time, you may be referred to a community professional that can further assist you.

For assistance today call:
24 hours a day—365 days a year

(800) 969-6162

or

(269) 660-3900

or log on to:

www.helpneteap.com

User id: rcs
Password: employee

Call any time, 24/7 or go online for confidential assistance, information or resources to help resolve life challenges.

Family & Medical Leave of Absences

Employees are required to notify HR if they will be absent for more than five (5) full consecutive days in order for a determination to be made as to whether the absence qualifies under the FMLA. Approved FMLA begins on the first day of the absence. FMLA is unpaid time off. Paid time is determined by individual employee contracts.

Employees may take a leave of absence for one of the following reasons:

- Birth of employee's child and to care for newborn child;
- Placement of a child with employee for adoption or foster care;
- To care for spouse, child or parent who has a serious health condition;
- When the employee's own serious health condition renders the employee capable of performing the functions of his/her job;
- Military Family Leave Entitlements (see Department of Labor website)

If the employee is not eligible for FMLA leave, they may request a personal or medical leave of absence. Medical and personal leave of absences requires the employee to follow the same instructions and provide the same documentation.

Step 1: Eligibility Requirements
To be eligible for FMLA, employees must have been employed by Rochester Community Schools for at least 12 months and worked 1,250 hours during the 12 month period preceding the commencement of the leave.

Step 2: Required Paperwork
Employees are asked to submit the Request for Leave of Absence to the HR Benefits Coordinator as soon as possible to begin the leave process. A meeting to discuss the leave of absence is recommended 30-60 days prior to first date of leave. A Certification of Healthcare Provider must be completed and returned 30 days prior to leave, if foreseeable.

Step 3: Notice of Eligibility and Rights & Responsibilities
If the employee does or does not meet the requirements for FMLA, the HR Benefits Coordinator will provide the Notice of Eligibility and Rights & Responsibilities paperwork to the employee within 5 days of when the employee submitted the FMLA paperwork.

Step 4: Designation Notice
The HR Benefits Department will provide the employee with a Designation Notice for the following reasons:

- Certification of Healthcare Provider has been received and FMLA is approved
- Employee needs to provide additional clarification to determine if the event qualifies under FMLA
- The event does not qualify for FMLA and is not approved
- Your have exhausted your FMLA leave entitlement in the applicable 12 month period

Step 5: Staff member's return from Leave of Absence
All employees are required to submit a "release to work" from their health care provider. This doctor's note needs to be submitted to the HR Benefits Department prior to the employee's first day back to work.

Paperwork and information is available on the RCS employee website.

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 your 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 document.

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.

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.

Legal Notices, continued

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.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a post-secondary 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.

Disclosure

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. Rochester 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, continued

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 July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://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)

CALIFORNIA – MEDICAID
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KIHIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740. TTY: Maine relay 711

Legal Notices, continued

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 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: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
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://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

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

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

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

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

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

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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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

Legal Notices, continued

Creditable Coverage Notice

Important Notice from Rochester 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 Rochester 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:

1. **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.**
2. **Rochester Community Schools has determined that the prescription drug coverage offered by the Rochester Community Schools 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 Rochester 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 Rochester 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, continued

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 Rochester 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 Rochester 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:	October, 2018
Name of Entity/Sender:	Rochester Community Schools
Contact—Position/Office:	Benefit/Human Resources
Address:	501 W. University Drive, Rochester, MI 48307
Phone Number:	248-726-3112

Contact Information

Provider/Benefit	Contact Information	
Blue Cross Blue Shield of Michigan (BCBSM) Medical	Claim and eligibility questions	(800) 637-2227
	To find PPO providers	(800) 810-2583 www.bcbsm.com
	Pharmacy questions Mail Order	(800) 239-1023 FAX # 800-841-5409
Blue Cross Blue Shield of Michigan (BCBSM) Dental	General info / finding a provider	(888) 826-8152 www.bcbsm.com/bluedental
Blue Cross Blue Shield of Michigan (BCBSM) Vision	General info / finding a provider	(866) 852-8947 http://www.heritagevisionplans.com/
BASIC Flexible Spending Accounts	Claim and service questions	(800) 444-1922 https://hrbenefitsdirect.com/BASIC
Dearborn National Basic Life/AD&D, Optional Life/AD&D, Long Term Disability	Life/AD&D & Long Term Disability Beneficiary Resources Travel Assistance	(800) 348-4512 (800) 769-9187 (877) 715-2593 (US & Canada)
HelpNet Employee Assistance Program	All Issues	(800) 969-6162 www.helpneteap.com User ID: rcs Password: employee
The OMNI Group 403(b)	All Issues	(877) 544-6664 www.omni403b.com or www.403bwhyme.com