ROCHESTER
COMMUNITY SCHOOLS

PRIDE IN EXCELLENCE

TEACHERS

2025 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.

Enrollment Opportunities

This Guide will give you an overview of the benefit plans we sponsor. You will need to make decisions about your 2025 benefit elections.

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

Eligible Employees

You are eligible for coverage under the Plan on your first day of employment if you are regularly scheduled to work thirty (30) hours or more per week.

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 calendar year 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 2025 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	$73.74	$176.97	$221.21	$65.00	$153.47	$188.67
21 Pay Periods	$91.29	$219.10	$273.88	$80.48	$190.01	$233.59

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 Benefit
Number of Opt-Outs	**Employee**	**Employee + One/Family**	
0-99	$75	$160	$50,000
100+	$160	$300	$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:

Find information about all aspects of the Affordable Care act, including links to state websites and coverage applications—https://www.healthcare.gov

For information on Medicaid eligibility—www.healthcare.gov/do-i-qualify-for-medicaid/

- **https://www.medicaid.gov/ - For more information on Medicaid.**

Medical Plans

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.

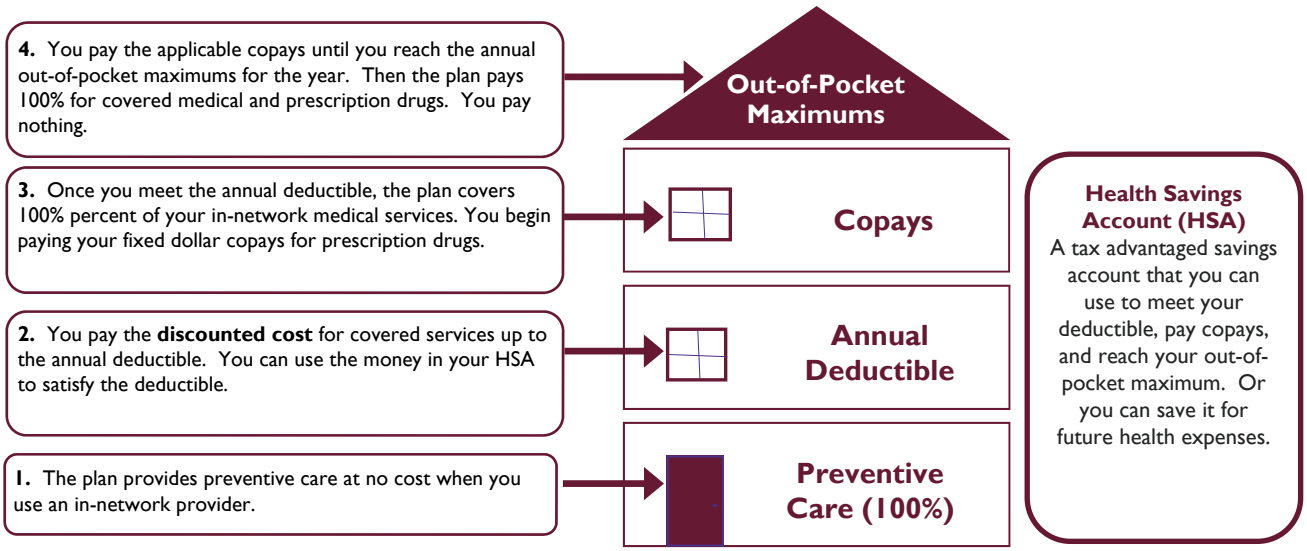
High Deductible Health Plans (PPO) with a Health Savings Account

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 2025 are $4,300 for single coverage and $8,550 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 2025 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, 2025 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 (2025), as well as all 12 months of the following calendar year—2026.

If you are not enrolled the entire 2025 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 Plan Comparison

	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 Primary Care Physician Specialist Online Visits	 $20 $20 $20	 30% after deductible 30% after deductible	Most services subject to deductible and coinsurance	
Emergency Room (waived if admitted)	$150	$150		
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- Retail	2x copay		2x 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	$1,650 individual $3,300 family The full family deductible must be met under a two–person or family contract before benefits are paid.	$3,300 individual $6,600 family
Annual Employer Funding to HSA	None		$825 for individual $1,650 for family	
Coinsurance Amounts (Percentage) Coinsurance Maximum (per calendar year)	Plan Pays 90% Member Pays 10% (most services) $1,000 individual $2,000 family	Plan Pays 70% Member Pays 30% (most services) $2,000 individual $4,000 family	Plan pays 100% Member pays 0% *After deductible None	Plan pays 80% Member pays 20% *After deductible 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-
https://www.rochester.k12.mi.us/about-us/departments/human-resources/benefitsfmlainjuryreporting

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 the doctor writes a prescription for a brand 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.

Prescription Drugs

High-Cost Drug Discount Optimization Program: Powered by PillarRx

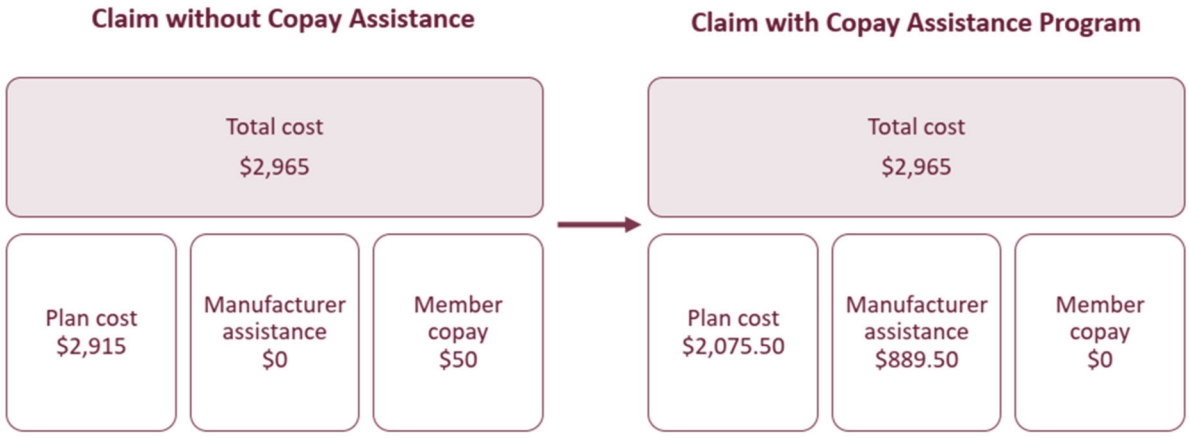
The PillarRx program will be in place for the BCBSM-PPO plan only. The HDHP with HSA is not included in the program. BCBSM will be mailing letters to those enrolled in the BCBSM-PPO plan who will be impacted.

BCBSM partners with PillarRx in a program in which drug manufacturers will assist in paying most or all of the member's copay on approximately 300 high-cost drugs.

If a member currently takes one or more medications for which copay assistance is available, he or she can expect a phone call from a PillarRx copay assistance team representative. The representative will help the member to enroll in the discount program, as well inform them how the program works, what they should expect at the pharmacy and answer any questions. **Members who take medications included in this program are required to enroll.**

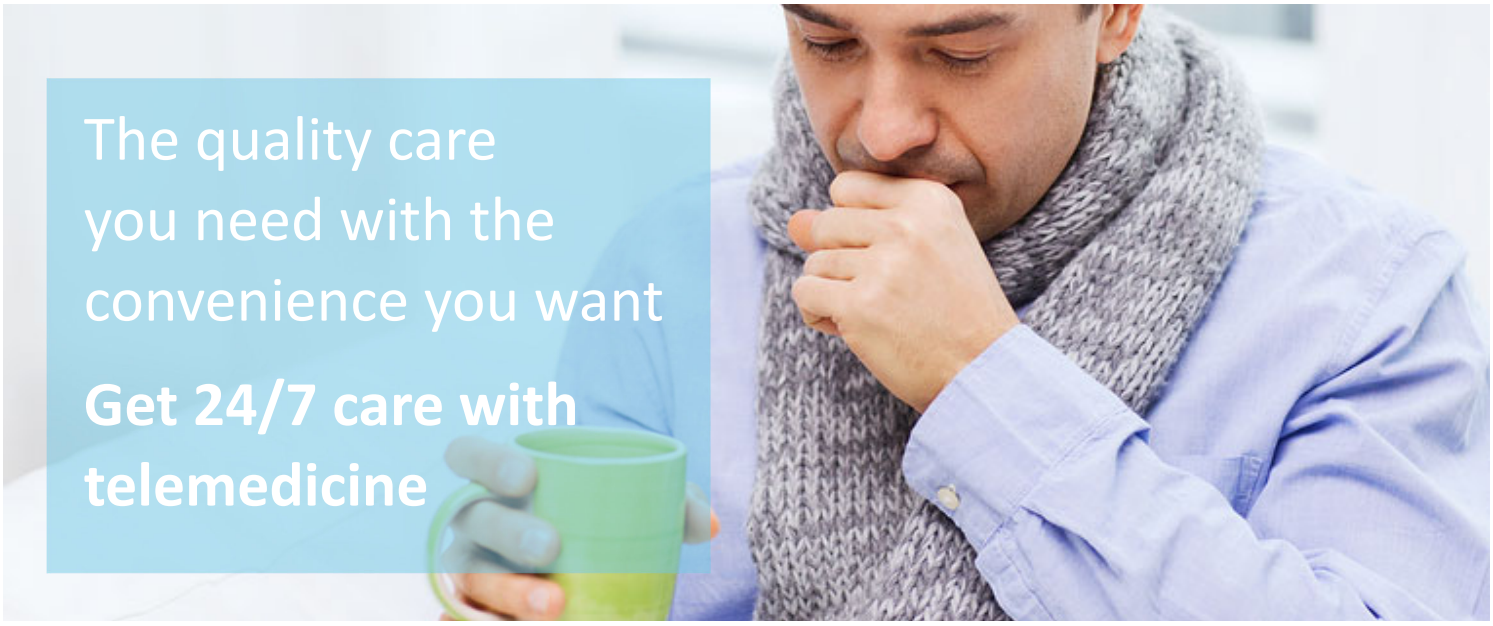
- **Members who enroll** will have all or a portion of their out-of-pocket costs (copay) for the drug covered by the drug manufacturer. Hence, in the example it shares a $0 copay to the member.
- **Members who ignore the letter / calls** and who do not enroll in the program will be responsible for a 30% coinsurance on the affected medication.

As such, there is a financial incentive for members to enroll in the program.



Members can call the PillarRx copay assistance team at (636) 614-3126 for more information.

Online Visits



Finding time to go to the doctor when you get sick can be a challenge, especially when it's for a routine illness, such as allergies or a cold. Save time and money by calling Blue Cross Online Visits!

What are Blue Cross Online Visits?

Blue Cross Online Visits provides you and your family members with 24/7 access to online medical and behavioral health services anywhere in the U.S. You'll talk to a U.S. Board Certified provider via phone or video consultation, who will diagnose and treat your issue. You'll save yourself the hassle and higher cost of going to the doctor's office. Prescriptions can also be called in to your pharmacy for added convenience!

What Can Be Treated By Blue Cross Online Visits?

- Allergies
- Cold
- Flu
- Sinus Infection
- Rashes
- Ear Ache
- Sore Throat
- Anxiety
- Grief
- Depression
- Pink Eye
- Poison Ivy
- Respiratory Infection
- Urinary Tract Infection

Note: Blue Cross Online Visits are available to all employees enrolled in medical coverage. You must register with Blue Cross Online Visits prior to your first consultation.

How Does It Work?

STEP 1: CREATE YOUR ACCOUNT

Sign up via phone, mobile app, or online.

1-800-835-2362

bcbsm.com/virtualcare

STEP 2: REQUEST A CONSULTATION

Access Blue Cross Online Visits via phone, mobile app, or online.

STEP 3: TALK WITH A PHYSICIAN

A physician will review your medical history and contact you within minutes.

STEP 4: RESOLVE THE ISSUE

A physician will diagnose and prescribe medication, if medically necessary, and send to your pharmacy of choice.

Dental Plan

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	$1,900	$1,900
Individual Lifetime Maximum for Class IV Services	$2,200	$2,200
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
https://www.rochester.k12.mi.us/about-us/departments/human-resources/benefitsfmlainjuryreporting

Vision Plan

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.

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

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

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 Ave., 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—$150 frame allowance	Member responsible for any cost exceeding the $150 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	$150 allowance applied toward contact lens exam and contact lenses*	$150 allowance applied toward contact lens exam and contact lenses*
*member responsible for any difference		

Life and AD&D

Basic Life and AD&D

The District provides a Basic Life and AD&D benefit of $50,000 to employees working a minimum of 0.4 full-time equivalent (FTE) or above. If you opt-out of Medical coverage through the District and work a minimum of 30 hours per week, you will receive an additional Life and AD&D benefit of $50,000 (for a total of $100,000 of coverage). Rochester Community Schools pays the full cost for this coverage. Your coverage is insured by **The Standard**.

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. These amounts are taxable to you 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 2-2 of IRS Code Section 79. For more information, consult your tax advisor.

Optional Life and 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 **The Standard**.

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. Employees can either elect or increase voluntary Life coverage by one increment each year during open enrollment.

Employee	$10,000 increments up to $500,000 Guarantee Issue Amount: $200,000
Spouse *	$10,000 increments up to $150,000 Guarantee Issue Amount: $50,000
Children	$2,500 increments up to a maximum of $10,000 Guarantee Issue Amount: $10,000

*In order for Spouse Life coverage to be elected, the employee must elect Additional Employee Life coverage. Additionally, the Spouse Life coverage cannot exceed 100% of the Additional Employee Life election. When the Employee or Spouse reach age 70, their respective coverage reduces to 50% of the original amount, per the Reduction In Insurance schedule.

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

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.

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:

- **Health Care Flexible Spending Account (HCFSA)**
- **Dependent Care Flexible Spending Account (DCFSA)**

BASIC administers the plan for Rochester Schools. When you elect an HCFSA BASIC will mail you a debit card that you can use to pay for eligible expenses, DCFSA expenses must be submitted manually.

If you enroll in the BCBSM CDHP, you are not eligible to participate in the Health Care Flexible Spending Account.

However, you are eligible to contribute to an HSA and/or Dependent Care Flexible Spending Account.

If you rolled over money in your Health Care Flexible Spending Account from 2024 to 2025, you are not eligible to make any contributions to an HSA.

With an HCFSA or DCFSA, you decide before the start of the year how much to contribute to each account. Your contributions are withheld in equal amounts on a pre-tax basis from your paychecks throughout the year. The money is set aside to use for out-of-pocket health care and dependent care expenses incurred during the plan year.

These accounts help you save money.

FSA 2025 Maximum Annual Contribution
Health Care: $3,300
Dependent Care: $5,000, or $2,500 if married and filing separate tax returns

How the Accounts Save You Money	Without a HCFSA or DCFSA	With a HCFSA or DCFSA
Gross Salary	$40,000	$40,000
Less Annual Amount Deposited into HCFSA/DCFSA	$0	($2,000)
Taxable Income	$40,000	$38,000
Less Annual Taxes (assumed at 25%)	($6,250)	($5,750)
Net Salary	$33,750	$32,250
Less Out-of-Pocket Health Care and/or Dependent Care Expenses for the Year	($2,000)	N/A
Disposable Income	$31,750	$32,250
Tax Savings	**None**	**$500**

Flexible Spending Accounts

HCFSA

The HCFSA helps you pay for medical, dental, and vision expenses that are not covered by insurance, such as copays and deductibles.

- You have immediate access to your entire HCFSA election as of January 1 (or, for new hires, as of your benefits eligibility date). You may be reimbursed up to your entire annual election at any point during the plan year, even if you have not yet contributed that amount to your FSA via payroll deductions.
- You may carry over up to $640 of unused funds remaining in your HCFSA at the end of a plan year. This amount may be used for eligible expenses incurred during the entire plan year in which it is carried over. Please note that any carry over amount is in addition to the annual maximum contribution that you can elect, which is $3,300. For example, if you carry over $600 from your 2025 HCFSA, those funds are available to you throughout 2026, until they are spent.
- The FSA Debit Card is used to pay for eligible health items and services at the point of sale. It can be used only at eligible locations where MasterCard is accepted. You may be asked by BASIC to provide substantiation whenever you use the FSA Debit Card. Please keep all documentation related to your FSA claims, such as itemized receipts and Explanations of Benefits. If you do not respond back to BASIC's request in a timely manner, your FSA Debit Card will be suspended from use until you either provide substantiation or repay the debited amount.
- For a complete list of the expenses eligible for reimbursement review Publication 502 on the IRS website.

DCFSA

The DCFSA helps you pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. **You can contribute up to $5,000 into the DCFSA in 2025.** But if both you and your spouse work, the IRS limits your maximum contribution to a DCFSA.

- 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 DCFSA, 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**.

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 is searching for work, is in school full-time, or is mentally or physically disabled and unable to provide the care.

Flexible Spending Accounts

DCFSA, continued

- You can only be reimbursed for dependent care expenses up to the amount you have already contributed to your DCFSA via payroll deductions. The full amount of your DCFSA election is not available on the first day of the plan year, January 1 (or, for new hires, as of your benefits eligibility date). If you file a claim for more than your balance, you will be reimbursed as new deposits are made.
- **There is no carry over feature for the DCFSA**. IRS regulations state money remaining in DCFSA accounts at the end of the plan year must be forfeited. This is referred to as the "use it or lose it" rule.
- Eligible dependent care expenses can either be reimbursed through the DCFSA or used to obtain the federal tax credit. You can not use both options to pay for the same expenses. Usually the DCFSA 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 Publication 503 on the IRS website.
- If you contribute to a DCFSA, 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.

For Both HCFSA and DCFSA, continued

Last Date to Submit FSA Claims for Reimbursement:

- **For the 2024 plan year**—Submit claims or provide debit card substantiation by March 31, 2025. Up to $500 remaining in the Health Care FSA after this date can be carried over into the 2024 plan year.
- **For the 2025 plan year**—Submit claims or provide debit card substantiation by March 31, 2026. Up to $500 remaining in the Health Care FSA after this date can be carried over into the 2025 plan year
- Dependent Care FSA claims must be incurred by December 31, 2025 for the 2025 plan year. All 2025 expenses must be submitted to BASIC Benefits by March 31, 2026.

Additional Services

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Health Advocate℠ to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.

Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and advance directives.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website for guidance on how to begin, to educate yourself on funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Death Benefit,[1] you may access the services for beneficiaries outlined on the next page.

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the beneficiary receives the Life claim letter from The Standard. Recipients of an Accelerated Death Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Care Managers with advanced training are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions.

  Our Care Managers may offer your beneficiaries additional grief support through support kits sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.
- **Legal Services:** In addition to online estate planning tools, your beneficiaries can obtain legal assistance from experienced attorneys. They can schedule an initial office visit or a telephone consultation for up to 30 minutes with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25% rate reduction from the attorney's normal hourly or fixed-fee rates.
- **Financial Assistance:** Your beneficiaries can schedule up to 30-minute telephone sessions with financial counselors who can help with issues such as budgeting strategies, and credit and debt management.
- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. WorkLife advisors can guide them to resources to help manage household repairs and chores, find child care and elder care providers or organize a move or relocation.
- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources about funeral costs, find funeral-related services and make decisions about funeral arrangements.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit **standard.com/mytoolkit (user name: support)** or call the assistance line at **800.378.5742**

Additional Services

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Download on the App Store

GET IT ON Google Play

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Must be arranged by Assist America, Inc.

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Travel Assistance EE
(6/20)

Sick Bank & Disability

Sick Bank

If you experience a short-term illness or disability, the first thirty (30) work days of illness or disability as described in the Leaves of Absence with Pay Article, will not be covered by the Bank, but must be covered by the person's own accumulated sick leave or by absence without pay. While drawing sick leave benefits a teacher cannot be receiving any other pay from the Board.

A teacher may draw up to 180 days from the Sick Leave Bank for the same illness in a two (2) school year period of time. If there is a reoccurrence of the same illness, additional days may be drawn from the Sick Leave Bank to the limit necessary to fill the elimination period to qualify for long term disability. The lifetime maximum for the sick bank is 180 days, regardless of whether it is for the same illness, or the number of years over which the sick bank years are drawn.

The Bank will be controlled by a committee composed of two teachers selected by the Association, and two administrators selected by the Superintendent. Final authority to grant or deny Bank benefits rests with the committee. Interpretation of the Bank policy will rest with the Board.

A teacher drawing from the Bank will receive eighty percent (80%) of his/her regular base contract pay.

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 The Standard.

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 $5,000
Elimination Period	330 days
Benefit Period	Benefits are payable up to age 65. 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.

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:
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.

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 ministries.

We recommended that all employees visit our education page which can be found here: **https://www.omni403b.com/Employees/Education**

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.

Future retirement savings value assuming 6% growth.			
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. You may then complete a Salary Reduction Agreement (SRA) at:

https://www.omni403b.com/SRA

If you are already contributing to your Employer's Plan and you want to change your contribution amount or investment provider, simply complete and submit a new SRA. You can begin or change your contributions as soon as your next payment cycle following our receipt of a completed SRA.

HOW MUCH CAN I CONTRIBUTE ANNUALLY?

In 2022, you may contribute up to $20,500 if you are 49 years of age and below and up to $27,000 if you are 50 years of age and over. Your plan may also permit additional catch up provision. Please contact OMNI's Customer Care Center at **877-544-6664** for tfurther details.

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
$20,500.00	$27,000.00	$3,000.00	$61,000.00	$61,000.00	$67,500.00

Looking for Help?

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

https://www.omni403b.com/PlanDetail

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 FORMERLY AXA
FIDUCIARY TRUST INTL FRANKLIN TEMPLETON
INVESCO OPPENHEIMERFUNDS
LINCOLN INVESTMENT PLANNING
LINCOLN NATIONAL
LPL FINANCIAL CORPORATION
MEA FINANCIAL SERVICES PARADIGM
METLIFE
ORION PORTFOLIO SOLUTIONS LLC FORMERLY FTJ FUNDCHOICE
PUTNAM INVESTMENTS
ROTH AIG RETIREMENT SERVICES FORMERLY VALIC
ROTH EQUITABLE FORMERLY AXA
ROTH INVESCO OPPENHEIMERFUNDS
ROTH LINCOLN INVESTMENT
ROTH MEA FINANCIAL SERVICES PARADIGM
ROTH METLIFE
ROTH VANGUARD FIDUCIARY TRUST CO
VANGUARD FIDUCIARY TRUST CO
AIG RETIREMENT SERVICES FORMERLY VALIC 457
EQUITABLE FORMERLY AXA 457
METLIFE 457

OMNI&TSACG Compliance Services

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 at
https://www.rochester.k12.mi.us/about-us/departments/human-resources/benefitsfmlainjuryreporting.

Legal Notices

Summary of Material Modification

The information in this document and in the benefit guide applies to the Rochester Community Schools. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

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. 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.

Midyear Election Changes to Pre-Tax Benefits

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 experience 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 elect or cancel 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.

Legal Notices

HIPAA Special Enrollment Rights

Rochester Community Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact David Murphy - Director of Human Resources & Employee Relations at 248-726-3118 or DMurphy@rochester.k12.mi.us.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above.

Legal Notices

If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: BCBSM—PPO (Individual: 90% coinsurance and $500 deductible; Family: 90% coinsurance and $1,000 deductible)
Plan 2: BCBSM—HDHP (Individual: 100% coinsurance and $1,650 deductible; Family: 100% coinsurance and $3,300 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 248-726-3118 or DMurphy@rochester.k12.mi.us.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

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

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting David Murphy - Director of Human Resources & Employee Relations at 248-726-3118 or DMurphy@rochester.k12.mi.us.

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

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NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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

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Notice of Creditable Coverage

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 medical 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 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Rochester Community Schools coverage as an active employee, please note that your Rochester Community Schools coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Rochester Community Schools coverage as a former employee.

You may also choose to drop your Rochester Community Schools coverage. 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.

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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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2025**
Name of Entity/Sender:	**Rochester Community Schools**
Contact—Position/Office:	**David Murphy - Assistant Superintendent of Human Resources**
Office Address:	**52585 Dequindre**
	Rochester, Michigan 48307
	United States
Phone Number:	**248-726-3118**

Contact Information

Provider/Benefit	Contact Information	
Blue Cross Blue Shield of Michigan (BCBSM) Medical	Claim and Eligibility Questions	(877) 790-2583 www.bcbsm.com
	To find PPO providers	(800) 810-2583 www.bcbsm.com
	Pharmacy questions Mail Order	(855) 811-2223 www.optumrx.com
Blue Cross Blue Shield of Michigan Dental	General Information & Finding a Provider	(888) 826-8152 www.bcbsm.com/bluedental
Blue Cross Blue Shield of Michigan Vision	General Information & Finding a Provider	(866) 852-8947 http:// www.heritagevisionplans.com/
BASIC Flexible Spending Accounts	Claims and Service Questions	(800)-444-1922 https://cda.basiconline.com/login
The Standard Basic Life/AD&D, Optional Life/AD&D, Long Term Disability	Life/AD&D & Long Term Disability Beneficiary Resources Travel Assistance (US & Canada)	(888) 937-4783 https://www.standard.com/ individual/contact/contact-us
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

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