2024 BENEFITS GUIDE

Farmington PUBLIC SCHOOLS

BENEFITS OVERVIEW

Farmington Public Schools is proud to offer a comprehensive benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this booklet. After reviewing the Benefit Guide, you will need to make decisions about the plan you elect.

You share the costs of some benefits (medical), and Farmington Public Schools provides other benefits at no cost to you. In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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BENEFITS OFFERED

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability
- Long Term Disability

ELIGIBILITY

New Hires: You are eligible for coverage under the Plan on your first day of employment if you are a full-time employee.

Eligible Employees: For specific eligibility details, refer to your bargaining unit contract.

Eligible Dependents: As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include your legal spouse and children , including natural, adopted, stepchildren, guardianship or children covered under a Qualified Medical Support Order, until the end of the calendar year in which they attain age 26. If your child is mentally or physically disabled or a full-time student, coverage may continue beyond age 26 once proper documentation is provided. This definition will apply to all plans unless the specific insurance carrier or plan definition is more restrictive.

If you 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 page 32 for more details.

Open Enrollment

During this period you may add, drop, or modify coverage. You will be locked into the plan selections from January 1, 2024 through December 31, 2024 unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status).

MAKING MID-YEAR CHANGES

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

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

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

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

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% of 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 you 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-medical/ - For information on Medicaid eligibility.
- https://www.medicaid.gov/ - For more information on Medicaid.

Medical Plans

Administered by BCBSM/BCN

Farmington Public Schools offers the following medical plan options:

- Blue Cross Blue Shield of Michigan — PPO
- Blue Cross Blue Shield of Michigan — PPO Consumer Driven Health Plan **(CDHP)** with a Health Savings Account **(HSA)**
- Blue Care Network — HMO
- Blue Care Network — HMO Consumer Driven Health Plan **(CDHP)** with a Health Savings Account **(HSA)**
- Opt-Out

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

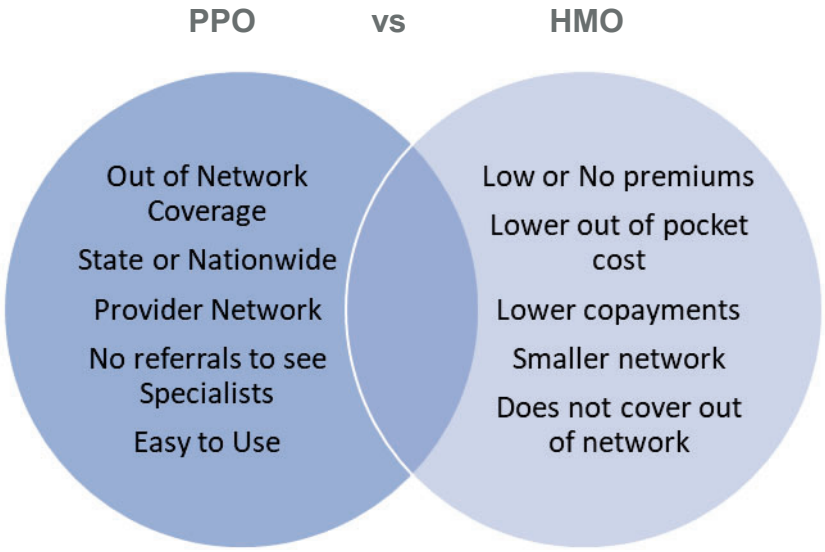
By self-funding, Farmington assumes a managed/capped financial risk, but in turn is able to adjust contributions and rates according to plan usage. Therefore, the more favorable our usage is, the more money available to keep cost increases to a minimum for our employees.

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.

"HMO" stands for Health Maintenance Organization. Blue Care Network (BCN) HMO is the largest HMO provider network in the state of Michigan with many primary care physicians and specialists to choose from and most of Michigan's leading hospitals. To find a BCN provider, visit www.bcbsm.com. When you enroll, you and each person in your family choose a Primary Care Physician, or "PCP". The PCP is the doctor you see for all of your care. If you need a specialist, need lab or x-ray work, or have to be admitted to the hospital, your PCP will handle it all. Remember that the first step to getting care is to call your PCP.

If you and your dependents are covered under another group medical and prescription drug plan, you may be eligible for the **Opt-Out**. This taxable bonus is paid annually during the month of December in lieu of medical and prescription drug coverage. You may choose to redirect your cash in lieu amount to your TSA account instead of receiving the taxable cash bonus in December. To be eligible to receive this bonus, you must complete the attestation acknowledgement on the Benefit Election Form every open enrollment.



Medical Plans

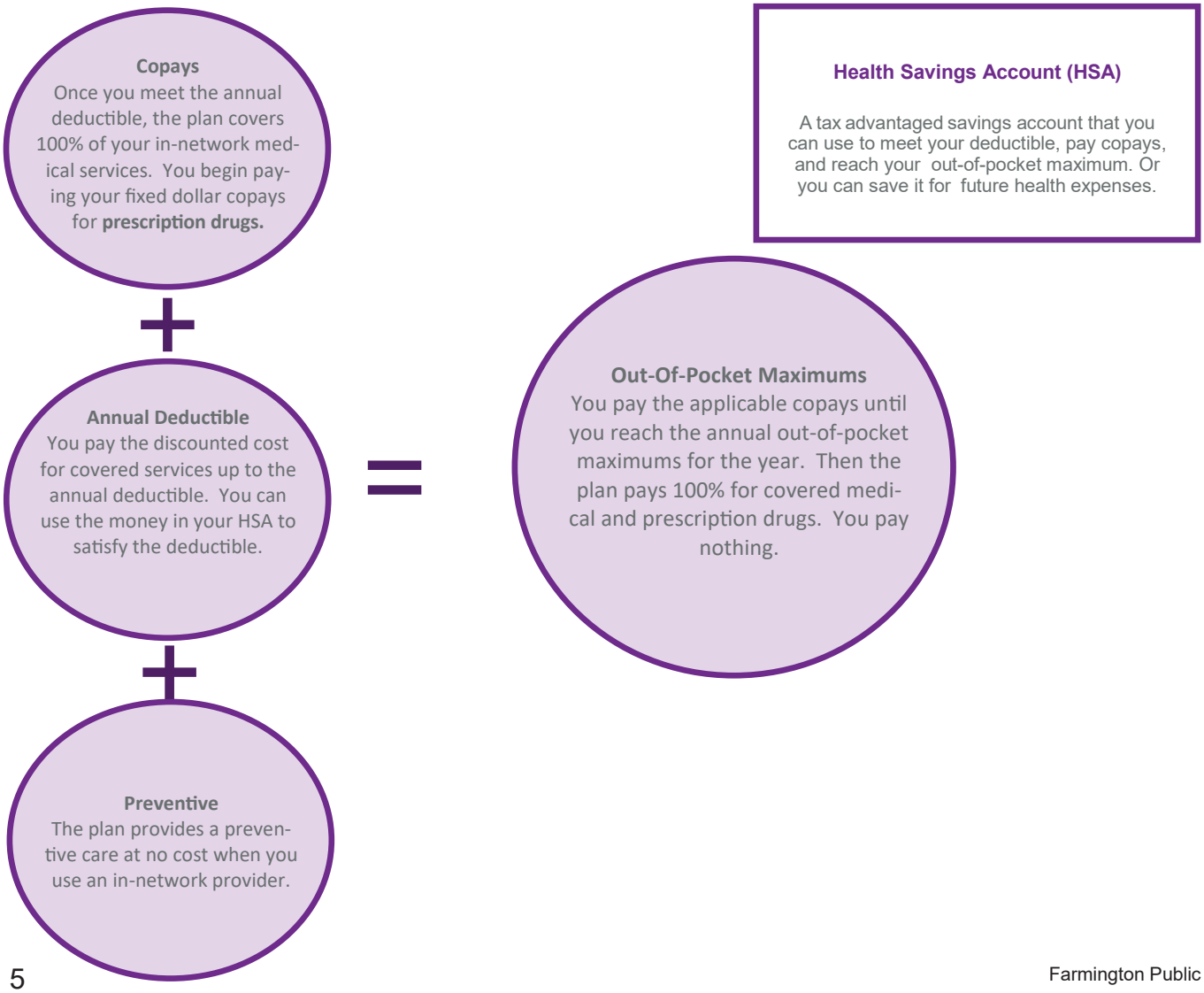
Consumer Driven Health Plans (PPO or HMO) with a Health Savings Account

The **Consumer Driven Health Plan (CDHP)** works much like our other PPO and HMO Plans. A consumer driven 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 and BCN CDHP. 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 CDHP works differently than the PPO or HMO Plans. Under the CDHP two person or family coverage, benefits for an individual will be payable only when the **FULL** family CDHP 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 or HMO plans.

How the High Deductible Health Plan Works



PPO &CDHP Comparison

	BCBSM-PPO		BCBSM-CDHP PPO	
	Network	Non-Network	Network	Non-Network
Preventive Services—Limitations Apply				
Health Maintenance Exam	100% coverage, one per calendar year	Not covered	100% coverage, one per calendar year	Not covered
Annual Gynecological Exam	100% coverage, one per calendar year	Not covered	100% coverage, one per calendar year	Not covered
Pap Smear Screening (lab only)	100% coverage, one per calendar year	Not covered	100% coverage, one per calendar year	Not covered
Well-Baby and Child Care	100% coverage, limits apply	Not covered	100% coverage, limits apply	Not covered
Immunizations	100% coverage, limits apply	Not covered	100% coverage, limits apply	Not covered
Mammography Screening	100% coverage	60% coverage after deductible	100% coverage	80% coverage after deductible
	One per calendar year		One per calendar year	
Copay Services				
Physician Office Services				
Primary Care Office Visits	$20 copay	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Online Visits	$20 copay	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Specialist Office Visits	$20 copay	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Emergency Medical Care				
Hospital Emergency Room	$50 copay, waived if admitted or for an accidental injury	$50 copay, waived if admitted or for an accidental injury	100% coverage after deductible	100% coverage after deductible
Urgent Care Center	$20 copay	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Ambulance Services	80% coverage after deductible	80% coverage after deductible	100% coverage after deductible	100% coverage after deductible
Prescription Drug Copays				
Pharmacy (30-day supply)		75% coverage after	After deductible,	After deductible, 75% coverage after,
Generic	$5	$5	$10	$10
Preferred Brand	$40	$40	$40	$40
Non-Preferred Brand	$80	$80	$40	$40
Mail Order (90-day supply)		Not covered	After deductible,	Not covered
Generic	2x copay		2x copay	
Preferred Brand				
Non-Preferred Brand				
Calendar Year Deductibles, Coinsurance and Maximums				
Deductible No fourth quarter carryover provision	$750 single $1,500 family	$1,500 single $3,000 family	$1,600 single $3,200 family	$3,200 single $6,400 family
			The full family deductible must be met under a two-person or family contract before benefits are paid.	
Coinsurance	80% coverage	60% coverage	100% coverage	80% coverage
Annual Coinsurance Maximum	$2,000 single $4,000 family	$4,000 single $8,000 family	Not applicable	Not applicable
Annual Out-of-Pocket Maximum (deductibles, coinsurance & copays)	$6,350 single $12,700 family	$12,700 single $25,400 family	$6,350 single $12,700 family	$12,700 single $25,400 family

PPO &CDHP Comparison

	BCBSM-PPO		BCBSM-CDHP PPO	
	Network	Non-Network	Network	Non-Network
Diagnostic Services				
Diagnostic Tests, Labs & X-Rays	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Maternity Services Provided by Physician				
Pre-Natal Care	100% coverage	60% coverage after deductible	100% coverage	80% coverage after deductible
Post-Natal Care	100% coverage	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Delivery & Nursery Care	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Hospital Care				
Physician Care, General Nursing, Hospital Services & Supplies	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Surgery & Related Surgical Services	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Alternatives to Hospital Care				
Skilled Nursing Care (must be participating skilled nursing facility)	80% coverage after deductible	80% coverage after deductible	100% coverage after deductible	100% coverage after deductible
	Limited to combined 120 days per calendar year.		Limited to combined 120 days per calendar year.	
Hospice Care (limits apply, must be participating program)	100% coverage	100% coverage	100% coverage after deductible	100% coverage after deductible
Home Health Care (must be participating home health care agency)	80% coverage after deductible	80% coverage after deductible	100% coverage after deductible	100% coverage after deductible
Mental Health Care and Substance Abuse Treatment				
Inpatient Mental Health & Substance Abuse	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Outpatient Mental Health & Substance Abuse	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Other Services				
Allergy Testing & Therapy	100% coverage	80% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Chiropractic Spinal Manipulation	$20 copay	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
	Limited to combined 24 visits per calendar year.		Limited to combined 24 visits per calendar year.	
Outpatient Physical, Speech, Occupational Therapy	80% coverage after deductible	60% coverage after deductible	100% coverage after deductible	80% coverage after deductible
	Limited to combined 60 visits per calendar year.		Limited to combined 60 visits per calendar year.	
Durable Medical Equipment (participating providers only)	80% coverage after deductible	80% coverage after deductible	100% coverage after deductible	100% coverage after deductible

HMO &CDHP Comparison

	BCN—HMO	BCN—CDHP HMO
Preventive Services—Limitations Apply		
Health Maintenance Exam *(one per calendar year)*	100% coverage	100% coverage
Annual Gynecological Exam *(one per calendar year)*	100% coverage	100% coverage
Pap Smear Screening (lab only) *(one per calendar year)*	100% coverage	100% coverage
Well-Baby and Child Care	100% coverage, limits apply	100% coverage, limits apply
Immunizations	100% coverage, limits apply	100% coverage, limits apply
Mammography Screening *(one per calendar year)*	100% coverage	100% coverage
Copay Services		
Physician Office Services		
Primary Care Office Visits	$20 copay	100% coverage after deductible
Online Visits	$20 copay	100% coverage after deductible
Specialist Office Visits	$20 copay	100% coverage after deductible
Emergency Medical Care		
Hospital Emergency Room	$50 copay after deductible, waived if admitted	100% coverage after deductible
Urgent Care Center	$20 copay	100% coverage after deductible
Ambulance Services	80% coverage after deductible	100% coverage after deductible
Prescription Drug Copays		
Pharmacy (30-day supply)		After deductible,
Generic	$5	$10
Preferred Brand	$20	$40
Non-Preferred Brand	$30	$40
Mail Order (90-day supply)	2x copay	After deductible
Generic		
Preferred Brand		2x copay
Non-Preferred Brand		
Calendar Year Deductibles, Coinsurance and Maximums		
Deductible	$500 single $1,000 family	$1,600 single $3,200 family The full family deductible must be met under a two-person or family contract.
Coinsurance	80% coverage	100% coverage
Annual Coinsurance Maximum	$1,000 single $2,000 family	Not applicable
Annual Out-of-Pocket Maximum (deductibles, coinsurance & copays)	$6,350 single $12,700 family	$6,350 single $12,700 family

HMO &CDHP Comparison

	BCN—HMO	BCN—CDHP HMO
Maternity Services Provided by Physician		
Pre-Natal Care	100% coverage	100% coverage
Post-Natal Care	$20 copay	100% coverage after deductible
Delivery & Nursery Care	80% coverage after deductible	100% coverage after deductible
Hospital Care		
Physician Care, General Nursing, Hospital Services & Supplies	80% coverage after deductible	100% coverage after deductible
Surgery & Related Surgical Services	80% coverage after deductible	100% coverage after deductible
Alternatives to Hospital Care		
Skilled Nursing Care *(must be participating skilled nursing facility)*	80% coverage after deductible, limited to 730 days per lifetime	100% coverage after deductible, limited to 730 days per lifetime
Hospice Care *(limits apply)*	100% coverage after deductible, when authorized	100% coverage after deductible
Home Health Care *(must be participating home health care agency)*	$20 copay after deductible	100% coverage after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health & Substance Abuse	80% coverage after deductible	100% coverage after deductible
Outpatient Mental Health & Substance Abuse	$20 copay after deductible	100% coverage after deductible
Other Services		
Allergy Testing & Therapy	100% coverage after deductible	100% coverage after deductible
Chiropractic Spinal Manipulation *(limited to 30 visits per calendar year)*	$20 copay after deductible	100% coverage after deductible
Outpatient Physical, Speech, Occupational Therapy *(limited to 60 visits per medical episode per calendar year)*	$20 copay after deductible	100% coverage after deductible
Durable Medical Equipment *(participating providers only)*	100% coverage	100% coverage after deductible

HOW THE PLANS WORK

Both plans use the BCBSM/BCN network and cover 100% of the cost for preventive care services like calendar year physicals and routine immunizations. The way you pay for care is different with each plan.

With the HDHP, you pay the full negotiated cost for medical services and prescription drugs until you meet your calendar year deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the calendar year out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the year. Your paycheck deductions for this plan are lower than the PPO plan.

The PPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum. This plan has higher paycheck deductions than the HDHP.

	HDHP	PPO or HMO Plan
Per-paycheck Cost for Coverage	$	$$
Calendar Year Deductible	$$	$
Calendar Year Out-of-pocket Maximum	$$	$$
Using the Plan	Pay less with each paycheck and more when you need care	Pay more with each paycheck and less when you need care
Spending Account Options	Health savings account (HSA) Dependent care FSA	Health care FSA Dependent care FSA

PAYING FOR HEALTH CARE

Farmington Public Schools offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	HSA	FSA
What medical plan can I choose?	HDHP	PPO OR HMO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on January 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	Yes, up to $500 carryover, funds remaining above $500 will be forfeited.
How do I pay for eligible expenses?	With your HealthEquity debit card (You can also submit claims for reimbursement online at www.healthequity.com)	With your Navia debit card (You can also submit claims for reimbursement online at www.naviabenefits.com)
How much can I contribute each year?	$4,150 for individual coverage or $8,300 for family coverage and additional $1,000 for catch up contributions in 2024	You can contribute $3,050 for individual coverage or $5,000 for family coverage in 2024
Can I change my contributions throughout the year?	Yes, you can submit the HSA Change Request Form on the benefits page to change your HSA contributions timed with the 1st payroll of the month.	No, unless you have a qualifying life event

BCBSM/BCN Online Visits

The platform for Online visits is changing effective January 1, 2024. Please follow the QR code below after January 1 to download the new app.

Virtual care that's always there

GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

With Virtual Care by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer.

Virtual Care is included with your Blue Cross Blue Shield of Michigan and Blue Care Network health care plan.

24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

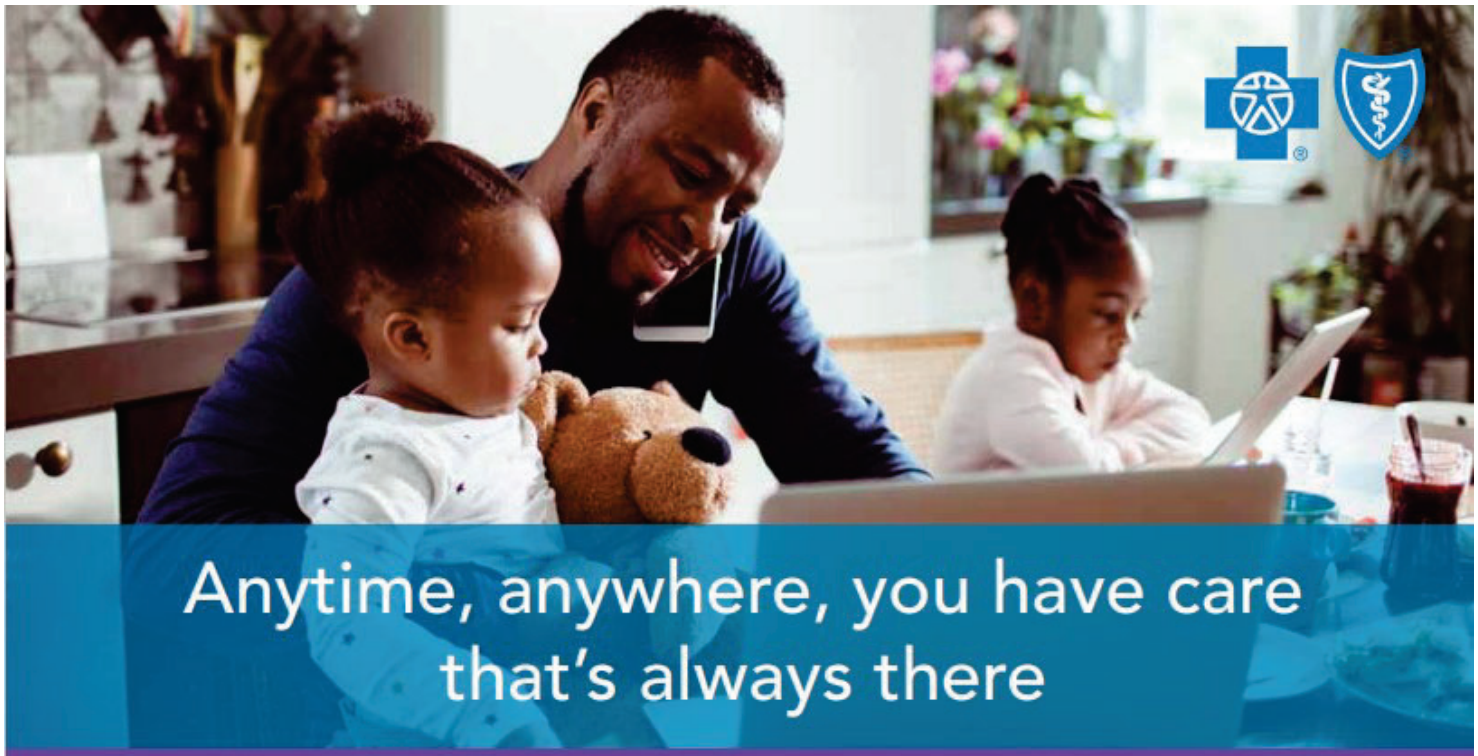
SIGN UP TODAY

Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1-800-835-2362** with any questions about your account or to arrange a telephone visit.

Visit Type	Cost prior to Deductible for CDHP's
Medical	$65
Psychotherapy (30 minutes)	$94.66
Psychotherapy (45 minutes)	$125.23
Psychiatry—Initial Visit	$246.21
Psychiatry—follow-up visit	$85.82

24-Hour Nurse Line



Have questions about a minor illness and your primary care provider isn't available? Talk to a registered nurse at no cost, anytime day or night, from the comfort of your home or anywhere else in the U.S. He or she will recommend treatment options or help you decide where to go for additional care.

The 24-Hour Nurse Line can help with minor medical conditions, such as:

- Abdominal pain
- Diarrhea
- Respiratory illness

Why use the 24-Hour Nurse Line?

- No cost
- Available by phone anytime, anywhere in the U.S.
- Service provided by a registered nurse

Save the number below to talk to a registered nurse for free.

Blue Cross members
1-800-775-2583

Blue Care Network members
1-855-624-5214

YOU HAVE CHOICES FOR CARE. LEARN MORE AT **BCBSM.COM/FINDCARE**.

Remember to coordinate all your care with your primary care provider. Follow up with him or her after receiving care elsewhere.

This information isn't intended to be medical advice. In an emergency, call 911 or go to an emergency room near you.

Blue Cross Blue Shield Blue Care Network of Michigan

Prescription Drugs

Prior Authorization & Step Therapy

Some prescription drugs may require Prior Authorization or Step Therapy. If you ’re taking or your physician writes you a prescription for a drug that requires Prior Authorization or Step Therapy, the prescription may not be dispensed until you obtain that authorization. The process requires that your physician contact the BCBS pharmacy help desk and coordinate the request. If it is an urgent request, your physician should make BCBS aware.

BCBS will notify both you and your physician in writing, by mail, if the request is approved or denied.

Preventive Drug Coverage

Under the Affordable Care Act, most health plans must cover certain preventive services and drugs with no cost-sharing. These include certain types of contraceptives, certain smoking cessation drugs, and prevention for a number of common conditions. For the full list of covered drugs please review the formulary.

Specialty Prescription Program

Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs treat complex and chronic conditions, including cancer, chronic kidney failure, multiple sclerosis, organ transplants, and rheumatoid arthritis

Specialty Mail Order Program

You can fill prescriptions for specialty drugs at a retail pharmacy, but not all pharmacies will dispense specialty drugs. Call your pharmacy in advance to verify that it can fill your prescription.

Blue Cross Blue Shield of Michigan also offers mail order service and support programs through Walgreens Specialty Pharmacy, an independent company that provides specialty pharmacy services for Blues members.

If you have questions about BCBSM’s specialty drug program, please call Walgreens Specialty Pharmacy at 1-866-515-1355 or visit the website at **WalgreensHealth.com**.

Specialty Drug Guide

Members can receive specialty drugs through the mail from Walgreens Specialty Pharmacy or get them at a retail specialty network pharmacy. They aren’t available through Express Scripts Home Delivery. For the most up-to-date list, please see the *Specialty Drug Guide* on **bcbsm.com** or call the Customer Service number on the back of your Blues ID card.

Quantity Limit Program

Blue Cross Blue Shield of Michigan set quantity limits based on clinical appropriateness and manufacturer recommended dosing for select drugs. For certain medications, BCBSM limit the quantity or maximum day supply that can be dispensed per fill.

Health Savings Account

Administered by HealthEquity

HealthEquity

Health Savings Account

- Health Savings Accounts (HSA) are available to employees enrolled in the Consumer Driven Health Plan (CDHP). 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 "consumer driven 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 CDHP. 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 2024 are $4,150 for single coverage and $8,300 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; and,
- 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 CDHP for only part of the 2024 calendar year, your contribution limits are prorated according to the number of months you are covered by a CDHP on the first day of the month.

If you are new in a CDHP and your first day in the CDHP is other than January 1, 2024 the IRS still allows you to contribute up to the annual maximum contribution for that year.

However, you must still be covered under the CDHP on December 1st of that same calendar year (2024), as well as all 12 months of the following calendar year—2024.

If you are not enrolled the entire 2024 calendar year, the IRS makes you pay tax on the extra contributions you made based upon the months you weren't enrolled in the CDHP, plus a 10% penalty on those excess contributions.

Flexible Spending Accounts

Administered by Navia

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)

Navia Benefits administers the plan for Farmington Schools. When you elect an FSA Navia Benefits will mail you a debit card that you can use to pay for eligible expenses.

If you enroll in the BCBSM or BCN 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 2023 to 2024, 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 through-out 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 2024 Maximum Annual Contribution

Health Care: $3,050

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	$25,000	$25,000
Less Annual Amount Deposited into HCFSA/DCFSA	$0	($2,000)
Taxable Income	$25,000	$23,000
Less Annual Taxes (assumed at 25%)	($6,250)	($5,750)
Net Salary	$18,750	$17,250
Less Out-of-Pocket Health Care and/or Dependent Care Expenses for the Year	($2,000)	N/A
Disposable Income	$16,750	$17,250
Tax Savings	**None**	**$500**

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 $500 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 $3,050. For example, if you carry over $350 from your 2024 HCFSA, those funds are available to you throughout 2024, 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 Navia 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 Navia'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 2024.** 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

Manual Reimbursement of Claims:

- Submit a claim form and the itemized receipt or explanation of benefits to Navia via mail or fax. The claim form is available from Human Resources or Navia's website at www.naviabenefits.com under the Tools/Resources Menu section.
- **You may also submit claims online (no forms are required).** If you have an email on file with Navia, you will receive a welcome email with instructions on how to register for the Participant Portal, found at www.naviabenefits.com. You must first register by clicking on "Register" at the top right, choose "I'm a participant" and then follow the steps to create a unique User ID and Password. Your Employee ID is the unique ID assigned to you by the Company (you can find this on your pay stub). **The Employer ID is FAI.**
- Claims are reimbursed weekly on Mondays for claims received during the preceding week. You may also sign up for direct deposit via the Participant Portal by clicking on your Name/Profile at the top right of the page and choosing "Update Bank Info". This brings up an online page to enter your bank account and routing numbers.

Participant Portal:

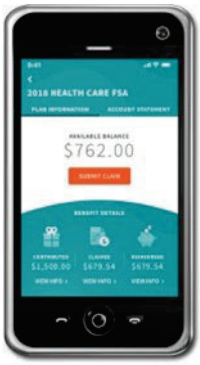
- Visit www.naviabenefits.com and enter your Username and Password under the Login section. You can review balances, account details, claims status and payment history. You can also securely file claims online as indicated above.
- Please review the FSA resources available on the Participant Portal. There is a video library, a calculator (including a worksheet to estimate how much you should contribute) and various tools. You will also find a link to IRS Publication 502 under "FSA Forms and Online Resources."

Flexible Spending Accounts

For Both HCFSA and DCFSA, continued

Mobile Application:

- You can get real-time access to your FSA information with Navia's mobile app. Download the app from the App Store (iPhones) or the Android Marketplace (Android phones). Enter the same Username and Password as you do for the Participant Portal to view your account balances and transactions. You can also upload receipts for debit card transactions or online claims by taking a picture with your phone.



DOWNLOAD the MyNavia mobile app

Search for "Navia" or "Navia Benefits" in the Apple App Store or Google Play Store

Available on the iPhone App Store

GET IT ON Google play

Last Date to Submit FSA Claims for Reimbursement:

- **For the 2023 plan year**—Submit claims or provide debit card substantiation by March 31, 2024. Up to $500 remaining in the Health Care FSA after this date can be carried over into the 2024 plan year.
- **For the 2024 plan year**—Submit claims or provide debit card substantiation by March 31, 2024. Up to $500 remaining in the Health Care FSA after this date can be carried over into the 2024 plan year
- Dependent Care FSA claims must be incurred by December 31, 2024 for the 2024 plan year. All 2024 expenses must be submitted to Navia Benefits by March 31, 2024.

Modified "Use It or Lose It" Rule for HCFSA

Our HCFSA allows a limited carry over of unused account balances of up to $500 from one plan year to the next. The additional funds that are carried over from the 2023 plan year won't be allocated to your 2024 account until after the end of the run-out period to submit claims for 2023 (March 31, 2024). You don't need to be enrolled in the HCFSA the subsequent plan year to be able to have up to $500 of the prior year balances allocated to the next plan year's account.

For example, if you have $400 remaining in your 2023 HCFSA as of March 31, 2024 (the end of the run-out period to submit claims for the 2023 Plan Year), but don't enroll during the open enrollment period, you will automatically have $400 allocated to your 2024 Plan Year HCFSA as of April 1, 2024 to use for expenses incurred anytime during the 2024 Plan Year.

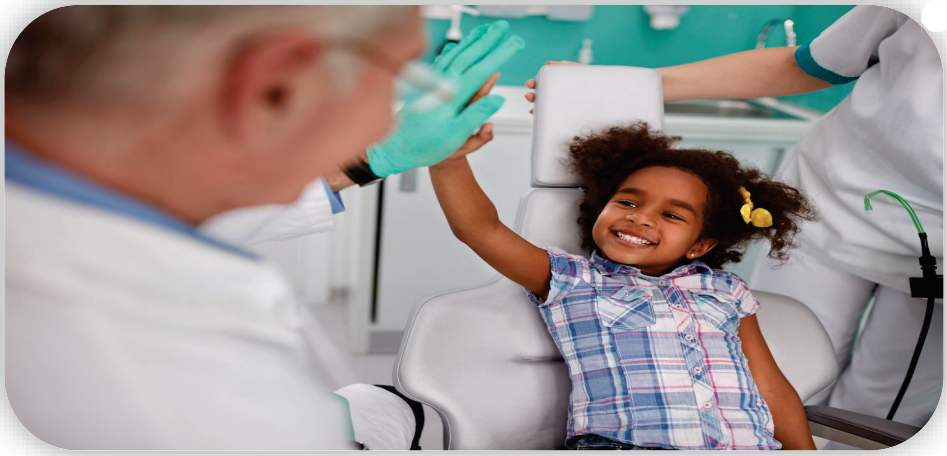
DENTAL BENEFITS

Administered by ADN

Our dental plan is self-funded and administered by ADN Administrators Inc., which utilizes two Preferred Provider Organization (PPO) networks—ADN Dental Network and Dentemax. Our dental plan allows freedom of choice, you may receive treatment from any licensed dentist or dental specialist. However, utilization of a PPO dental provider will substantially reduce your out-of-pocket dental expenses and overall dental benefit costs.

Participating PPO dentists will adhere to ADN's processing policies and are prohibited from billing a patient above the pre-negotiated fee, accepting billing under these terms as payment in full.

	Plan A	Plan B	Plan C
	Without Coordinated Dental Coverage	**With Coordinated Dental Coverage**	**With or Without Coordinated Dental Coverage**
Eligibility	FEA, ESP, FMC, FTA, Administration, FASA, Non-Unit	FEA, ESP, FMC, FTA, Administration, FASA, Non-Unit	Part-Time Food Service, Part-Time Support Staff
Type I—Preventive/Diagnostic Preventive & Diagnostic Emergency Palliative Treatment & Radiographs	100% coverage	50% coverage	50% coverage
Type II—Basic Oral Surgery, Fillings, Endodontics, Periodontics, Restorative Services	90% coverage	50% coverage	50% coverage
Type III—Major Restorative Prosthodontics & Major Restorative Services	90% coverage	50% coverage	50% coverage
Annual Benefit Maximum Type I, II & III Services	$2,000 per person	$2,000 per person	$500 per person
Type IV—Orthodontic Services Orthodontics	90% coverage	90% coverage	Not covered
Lifetime Maximum Orthodontics	$2,000	$2,000	Not applicable



New for 2024!

Sealants are now covered without age restrictions.

4 periodontal cleanings per year are available for each covered member.

The benefit year is based on the calendar year—January 1—December 31. The Dental Plan's Predetermination amount is $250.

VISION BENEFITS

Administered by NVA

Our vision plan is self-funded and is administered by NVA Vision.

You will receive maximum benefits when you receive care from a participating network provider. You may receive care from a non-network provider, but you'll pay more out-of-pocket because non-network providers will require that you pay 100% of the cost at the time of service and submit the itemized invoice to NVA for refund to obtain the direct reimbursement according to your plan design.

You can still search our providers online at www.e-nva.com by selecting the "Find Provider" link on the home page. Enter group number 13920001 and enter your search parameters. You can also search for providers, access your digital ID card, and view your benefits through the NVA Mobile App. Just search NVA in the store of your IPhone or Android.

At the time of your appointment, simply indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit the website at www.e-nva.com, access the NVA mobile app or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year.

Hearing Aid Discount for NVA Members

NVA Vision offers a benefit to their members to help save on hearing aids through NationsHearing. Program features include the following:

- Annual hearing test with no out of pocket cost
- Access to a nationwide network of 8,000+ providers
- State-of-the-art hearing aids from all major manufactures
- Low pricing and 60-day 100% money back guarantee
- Concierge services by dedicated Member Experience Advisors
- Three follow-up visits with your provider
- 3-year manufacturer's repair warranty
- 3 years of batteries*
- One-time replacement coverage for lost, stolen or damaged hearing aids**
- 12 or 18 month financing options available with 0% APR, no money down

To get started, call 877-272-9627

VISION BENEFITS

	Network	Non-Network
Eye Exams—*One exam every calendar year*		
Optometrist	Covered at 100%	Maximum benefit of $35
Ophthalmologist	Covered at 100%	Maximum benefit of $45
Eyeglass Lenses (Standard Glass or Plastic)—*One pair of lenses, with or without frames, every calendar year*		
Lens		
Single Vision	Covered at 100%	Maximum benefit of $38
Bifocal	Covered at 100%	Maximum benefit of $60
Trifocal	Covered at 100%	Maximum benefit of $72
Lenticular	Covered at 100%	Maximum benefit of $108
Solid Tints		
Single Vision	Covered at 100%	Maximum benefit of $4
Bifocal	Covered at 100%	Maximum benefit of $10
Trifocal	Covered at 100%	Maximum benefit of $12
Lenticular	Covered at 100%	Maximum benefit of $10
Fashion Gradient Tints		
Single Vision	Covered at 100%	Maximum benefit of $4
Bifocal	Covered at 100%	Maximum benefit of $10
Trifocal	Covered at 100%	Maximum benefit of $12
Lenticular	Covered at 100%	Maximum benefit of $10
Polarized		
Single Vision	Covered at 100%	Maximum benefit of $18
Bifocal	Covered at 100%	Maximum benefit of $30
Trifocal	Covered at 100%	Maximum benefit of $38
Lenticular	Covered at 100%	Maximum benefit of $30
SV Polycarbonate (under age 19)	Covered at 100%	Not applicable
Blended Bifocals	Covered at 100%	Not applicable
Glass Photogrey	Covered at 100%	Not applicable
Oversized	Covered at 100%	Not applicable
Standard Progressives	Covered at 100%	Not applicable
Premium Progressives	Covered at 100%	Not applicable
Rimless Mounting	Covered at 100%	Not applicable
Transitions	Covered at 100%	Not applicable
Frame/Rimless Frame—*One frame every calendar year*		
Standard Frame	Maximum benefit of $180 (30% discount off balance over the $180 allowance)	Maximum benefit of $116
Contact Lenses (In Lieu of Lenses & Frames)—*One every calendar year, allowance includes fitting fee and exam*		
Medically Necessary	Covered at 100%	Maximum benefit of $250
Elective	Maximum benefit of $250 (25% discount off balance over the $250 allowance)	Maximum benefit of $165

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the pricing list below:

$10 Standard Scratch-Resistant Coating	$55 High Index
$12 Ultraviolet Coating	$25 Polycarbonate (Single Vision) 19 & over
$40 Standard Anti-Reflective	$30 Polycarbonate (Multi-Focal) 19 & over

Options not listed will be priced by NVA providers at their R&C retail price less 20%.

LIFE INSURANCE BENEFITS

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LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by Unum

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Farmington Public Schools. The District provides basic life insurance at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Farmington Public Schools provides AD&D coverage at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Employee Class	Basic Life/AD&D Amount
Assistant Superintendent, Executive Directors, Central Office Administrators	$200,000
Directors, FASA	$150,000
Non-Unit A Personnel	$100,000
Non-Unit B Personnel	$75,000
FEA, ESP, CMC,FTA, Headstart Grandfathered	$50,000
Part-Time Support, Part-Time Nutrition	$30,000
All Classes– Age Reduction	At age 75 benefits reduce to 50%

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.

LIFE INSURANCE BENEFITS

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OPTIONAL LIFE AND AD&D

Administered by Unum

You have the opportunity to purchase Optional Life and AD&D insurance for yourself, your legal spouse and your children through post-tax payroll deductions. In order to purchase coverage for your spouse or children, you must first purchase Optional Life and AD&D coverage for yourself. Your election will remain inforce for the entire calendar year, unless you have a qualified change in status.

The amount of insurance on your dependent(s) will not exceed 100% of your election. An employee cannot be covered twice under the Optional Life and AD&D plan as an employee and dependent. A dependent child cannot be covered twice under the Optional Life and AD&D plan as a dependent of two married employees.

Individual	Optional Life/AD&D Amount
Employee	$10,000 increments up to the lesser of five time your annual earnings or $200,000
Spouse	May elect up to 100% of employee's election, up to $40,000, in $5,000 increments
Child(ren) 6 months to end of the calendar year in which they attain age 26	May elect up to 100% employee's election, up to $10,000, in $2,000 increments *Newborns to age 6 months– maximum benefit is $1,000
Do You Need to Provide Medical Information (Evidence of Insurability)	
No, if you are **currently enrolled** and are electing to increase or decrease your coverage amount. **Yes**, if you **did not elect coverage** when initially eligible and later decide to elect coverage. Coverage does not become effective until your request has been approved by Unum.	
Employee and Spouse elections are subject to age reduction based on the employee's age. When the employee reaches age 75 the benefits reduce to 50% of elected coverage.	

Long Term Disability

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We offer a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. Farmington Schools pays the full cost of coverage and it is insured by Unum.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence, on the date that insurance would otherwise become effective. Review the carrier certificate / benefit booklet for details on these and other important provisions.

Item	Long Term Disability Benefit
Monthly Benefit	FASA, Assistant Superintendent, Executive Director, Directors, Non-Unit A & B Personnel, Administrators: 66-2/3% of monthly earnings to a maximum of $9,723 FEA: 66-2/3% of monthly earnings to a maximum of $6,945 ESP, CMC, FTA: 66-2/3% of monthly earnings to a maximum of $6,111 Earnings are defined as base monthly income in effect just prior to your date of disability, including pre-tax deductions. It does not include overtime pay, bonuses, commissions, and other extra income or income received from sources other than your Employer. Your benefit may be reduced by deductible sources of income and disability earnings.
Elimination Period	Your elimination period is the greater of 120 consecutive calendar days or the end of your sick pay. You must be continuously disabled through your elimination period.
Benefit Period	Benefits are payable up to age 65 or longer in some cases depending on your age at disability. Disabilities which are primarily based on disabilities due to mental/nervous or substance abuse conditions, have a limited benefit period up to 24 months.
Definition of Disability	You are disabled when Unum determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. You can be totally or partially disabled during the elimination period.
Pre-existing Conditions	Benefits are not payable for a disability due to pre-existing condition. A pre-existing condition means you: • received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to his or her effective date of coverage; and • the disability begins in the first 12 months after your effective date of coverage.

Optional Short Term

Our Optional Short Term Disability (STD) plan pays you income if you are disabled from work due to a non-work related illness or injury. Coverage is insured through Unum.

We offer you the opportunity to purchase Optional Short Term Disability (STD) coverage for yourself through post-tax payroll deductions. Your election will remain inforce for the entire calendar year, unless you have a qualified change in status.

Your coverage effective dates and increases in coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence, on the date that insurance would otherwise become effective. Review the carrier certificate / benefit booklet for details on these and other important provisions.

Item	Short Term Disability Benefit
Weekly Benefit	$100 increments up to the lesser of 60% of your weekly earnings or $1,000 Earnings are defined as base weekly salary in effect just prior to you date of disability, not including commissions, bonuses, or overtime.
Elimination Period	Benefits begin on the 8th consecutive day for disabilities due to injury or sickness.
Benefit Period	Benefits are payable for up to 17 weeks.
Definition of Disability	Disability an disabled mean that you are limited from performing the material and substantial duties of your occupation due to sickness or injury and you have a 20% or more loss in weekly earnings due to the same sickness or injury.
Pre-existing Conditions	Benefits are not payable for a disability due to pre-existing condition. A pre-existing condition means you: • received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to his or her effective date of coverage; and • the disability begins in the first 12 months after your effective date of coverage. **In addition, this plan will not cover an increase in coverage made during an annual enrollment period if the employee has a pre-existing condition.**
Medical Information (Evidence of Insurability)	If you did not elect coverage when initially eligible and later decide to elect coverage, you must submit a medical questionnaire (evidence of insurability) to Unum. Coverage may be denied based on your medical condition.

Travel Assistance

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Administered by Unum

Unum contracts with Assist America to provide you with emergency travel assistance. Whenever you travel 100 miles or more from home—to another country or just another city—be sure to pack your worldwide emergency travel assistance phone number. Travel assistance helps you locate hospitals, embassies and other unexpected travel destinations. Just one phone call connects you and your family to medical and other important services 24 hours a day.

Call travel assistance for access to:

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

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

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

With the Assist America Mobile App, you can:

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

Download and activate the app from the Apple App Store or Google Play, Reference Number: 01-AA-UN-762490.

Unum's travel assistance services are provided by Assistance America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are available to help 24 hours a day, 365 days a year.

Employee Assistance Program

Administered by Ulliance

Farmington Schools is offering an Employee Assistance Program (EAP), through Ulliance. The Ulliance EAP program provides confidential assistance for you and your eligible family members to help you resolve any concerns that are affecting your personal or work life.

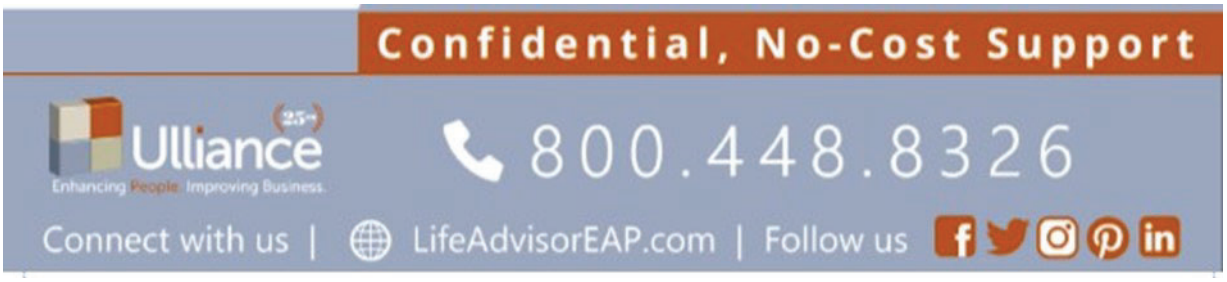
Ulliance can provide assistance or referrals for the following issues:

- Child care resources.
- Elder care referrals.
- Family and children problems.
- Financial concerns.
- Grief and loss issues.
- Legal issues.
- Alcohol or other drug use.
- Marital and relationship conflicts.
- Stress or other emotional difficulties.

Ulliance offers a state-of-the-art interactive website with thousands of available articles and information on various work/life topics.

Ulliance offers confidential assessment, personal coaching, in-person consultation and short-term counseling, as well as crisis intervention and referrals. If you decide that you would like or need services beyond the EAP, your Ulliance counselor will assist you in obtaining continued care, utilizing your health care benefits, community resources or sliding fee scale treatment provider.

Use of the EAP is free and confidential. There are no out-of-pocket expenses for either you or your eligible family members to use the EAP. If extended counseling is needed beyond the EAP, your health care insurance plan provisions may apply.



LEGAL NOTICES

Summary of Material Modification

The information in this document and in the benefit guide applies to the Farmington Public 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, the Health and Welfare Benefits Notices, 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. Farmington Public 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 to 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

Farmington Public Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Farmington Public 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 Human Resources.

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. 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.

LEGAL NOTICES

Women's Health & Cancer Rights Act

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

- All 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: 80% coinsurance and $750 deductible; Family: 80% coinsurance and $1,500 deductible)

Plan 2: BCBSM-CDHP PPO (Individual: 100% coinsurance and $1,500 deductible; Family: 100% coinsurance and $3,000 deductible)

Plan 3: BCN—HMO (Individual: 80% coinsurance and $500 deductible; Family: 80% coinsurance and $1,000 deductible)

Plan 4: BCN—CDHP HMO (Individual: 100% coinsurance and $1,500 deductible; Family: 100% coinsurance and $3,000 deductible)

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

The Farmington Public Schools maintains a Notice of Privacy Practices that provices information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of privacy Practices, please contact Human Resources.

Patient Protections Disclosure

The Farmington Public Schools Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Network at 800-662-6667 or www.bcbsm.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at 800-662-6667 or www.bcbsm.com.

LEGAL NOTICES

Children's Health Insurance Program (CHIP)

Qualified group health plans in States that provide medical assistance through either Medicaid or a Children's Health Insurance Program (CHIP or SCHIP) must provide a notice informing employees of the potential opportunity for state Medicaid or CHIP health care assistance for group health plan coverage. The notice must be provided to employees when initially eligible and during the annual enrollment.

State-specific information must also be included in the notice. We have not included that information here because portions of the information such as phone numbers change periodically. An updated model notice is available on the DOL's Employee Benefits Security Administration's (EBSA) website at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.doc

LEGAL NOTICES

Notice of Creditable Coverage

Important Notice from Farmington Public Schools

About Your Prescription Drug Coverage and Medicare

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

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

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. **Farmington Public 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 Farmington Public Schools coverage as an active employee, please note that your Farmington Public 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 Farmington Public Schools coverage as a former employee.

You may also choose to drop your Farmington Public Schools coverage. If you do decide to join a Medicare drug plan and drop your current Farmington Public Schools coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Farmington Public 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 Farmington Public Schools changes. You also may request a copy of this notice at any time.

LEGAL NOTICES

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).

Date:	**January 01, 2024**
Name of Entity/Sender:	**Farmington Public Schools**
Contact—Position/Office:	**Benefits Department**
Office Address:	**32500 Shiawassee, Farmington MI 48336**
Phone Number:	**248-489-3354**

Glossary of Terms

MEDICAL

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

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

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

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

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

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

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

Eligible Dependents – A child (until the end of the calendar year in which they attain age 26) who is your natural child, adopted, under your legal guardianship, placed with you for adoption, or a stepchild.

If your child is mentally or physically disabled or a full-time student, coverage may continue beyond age 26 once proper documentation is provided.

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

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

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

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

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

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

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

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

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

Routine and Preventive Visits –Office visits for Wellness and Routine Physical (services include Well Child Care, Immunization, Routine Gynecological Exam and Pap Smear, Mammogram, PSA Test and Related tests.

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

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

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

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

Glossary of Terms

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

In-Network Participating Providers – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with BCBSM to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept the BCBSM approved amount as payment in full for covered services.

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

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

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

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

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

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

PRESCRIPTION DRUGS

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

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

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

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

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

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

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

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

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

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

Glossary of Terms

DENTAL

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

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

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

EOB – See Medical.

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

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

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

FLEXIBLE SPENDING ACCOUNTS (FSA)

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

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

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

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

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

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

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

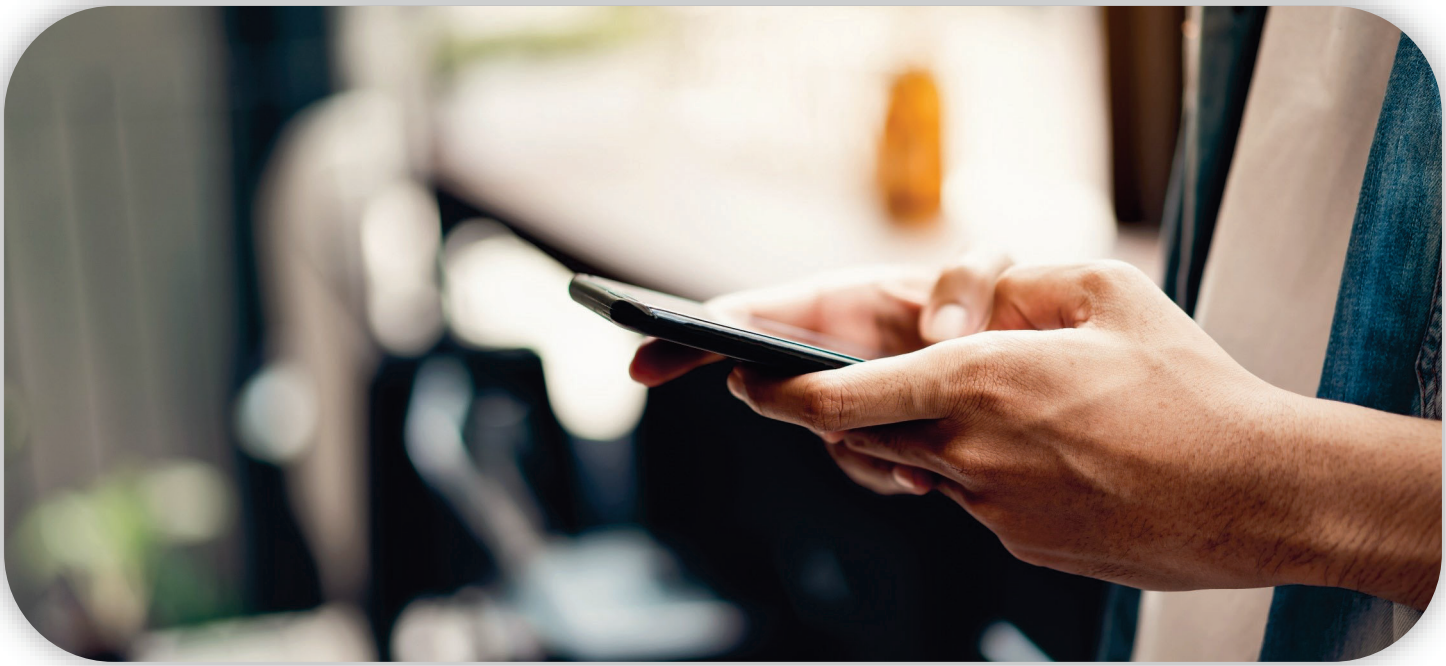
Use-it-or-Lose-it – Any balance in the Health Care or Dependent Care Spending Accounts that is not used for eligible expenses within the plan year will be forfeited.

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

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or the Benefits Department at fpsbenefits@fpsk12.net or (248) 489-3354.

BENEFIT	ADMINISTRATOR	CONTACT INFORMATION	
Medical	Blue Cross Blue Shield of Michigan (BCBSM) PPO's	Member Services Locate Providers Pharmacy	(877) 790-2583 (800) 810-2583 (800) 437-3803 www.bcb sm.com
Medical	Blue Care Network (BCN) HMO's	Member Services	(800) 662-6667 www.bcbsm.com
Health Savings Account	Health Equity	General Information	(866) 346-5800 www.healthequity.com
Flexible Spending Accounts	Navia Benefits Group	General Information	(800) 669-3539 www.naviabenefits.com
Dental	ADN Administrators, Inc.	General Information	(248) 901-3705 (888) 236-1100 www.adndental.com
Vision	NVA	General Information	(800) 672-7723 www.e-nva.com
Life, AD&D, Optional life/AD&D, Optional Short Term Disability, Long Term Disability	Unum	General Information	(800) 421-0344 www.unum.com
Travel Assistance	Assist America through Unum	General Information	(800) 872-1414 (609) 986-1234 (U.S. access code) www.unum.com/travelassistance
Employee Assistance Plan (EAP)	Ulliance	Member Services	(800) 448-8326 www.ulliance.com



This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting