



ROCHESTER COMMUNITY SCHOOLS

PRIDE IN EXCELLENCE

PARAEDUCATORS

HIRED AND ELIGIBLE BEFORE AUGUST 1, 2011



2025 Benefit Guide



Department of Human Resources

501 W. University Drive Rochester, MI 48307

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

WELCOME TO ROCHESTER COMMUNITY SCHOOLS!

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

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

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

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

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

To access our website please go to:

www.rochester.k12.mi.us

Click on the District Info > Human Resources



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Information about Medicare

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



Important Information

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

Enrollment

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

Open Enrollment

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

New Hire Enrollment

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



Making Mid-Year Changes

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

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

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

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

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



Eligibility

Eligible Employees

You are eligible for coverage under the Plan if you are a permanent full time employee who has completed 90 calendar days of employment, hired before August 1, 2011 and are regularly scheduled to work six (6) hours or more per day.

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

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 policies will deem you ineligible for one year.

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

Eligible Dependents

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

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

Dependent Eligibility Rules and Documentation Requirements

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

Spouse—A copy of the marriage license.

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

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



Employee Contributions

Listed below are the 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
20 Pay Periods	\$95.33	\$228.78	\$285.97	\$84.51	\$199.51	\$245.27

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		
Number of Opt Outs	Monthly Cash Option	Additional Life and AD&D
1-20	\$75	\$50,000
21-34	\$100	\$50,000
35+	\$125	\$50,000

Medicaid Expansion

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

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

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

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

Medical



Rochester Community Schools offers the following medical plan options:

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

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

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

About Your Plans

“**PPO**” stands for Preferred Provider Organization. As a BCBSM PPO member, you have access to the worldwide network of BCBSM PPO providers. To find BCBSM PPO providers, visit www.bcbsm.com. You don’t need to choose a Primary Care Physician with a PPO—you can see any provider you want to see, even a specialist. There’s a lot of freedom with PPO plans. You can see non-PPO providers, but your benefits will be reduced and you’ll pay more out-of-pocket.

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

BCBSM—Save Money and Live Healthier with Blue365

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

Member discounts with Blue365 offers exclusive deals on things like:

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

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



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

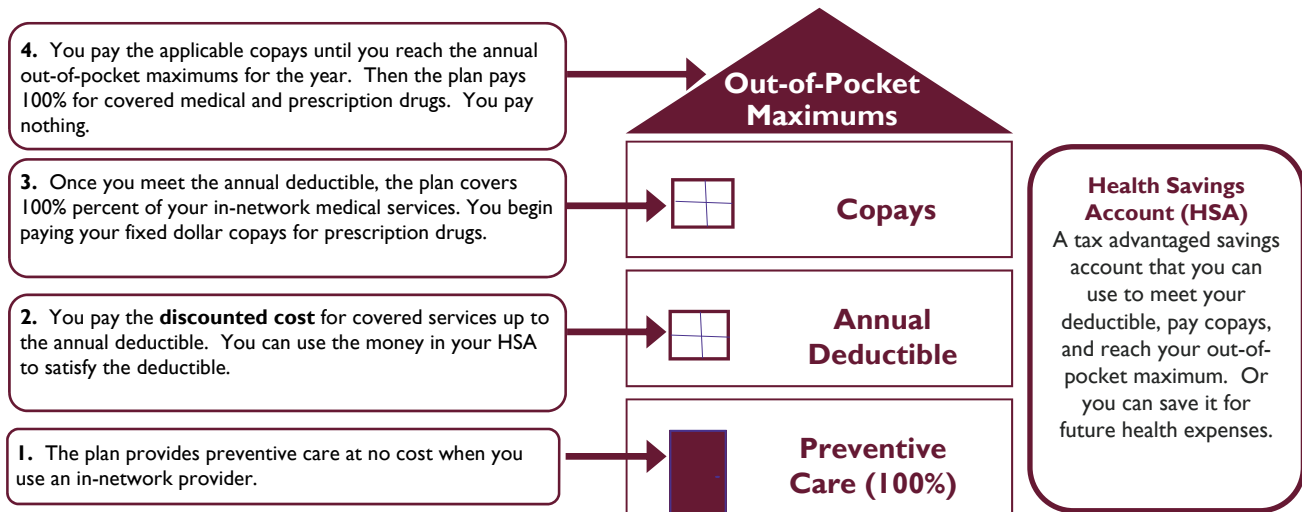
The **High Deductible Health Plan (HDHP)** works much like our other PPO Plans. A *high deductible health plan* pairs a high-deductible, lower premium health plan with a tax-free **Health Savings Account (HSA)** that reimburses you for current and future medical expenses. All services, including prescriptions 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



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 (HSAs) 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 Plans



	BCBSM—PPO		BCBSM— HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Copay Services				
Preventive Care Visit (One per member per year)	100%	Not Covered	100%**	Not Covered
Office Visits	\$20	30% after deductible	Most services subject to deductible and coinsurance	
Urgent Care	\$20	30% after deductible		
Emergency Room (waived if admitted)	\$250	\$250		
Urgent Care	\$20	30% after deductible		
In-Network Prescription Drug Copays				
Generics	\$5		\$10 copay after deductible	
Preferred Brand	\$35		\$40 copay after deductible	
Non-Preferred Brand	\$50		\$80 copay after deductible	
90 Day Supply- Mail Order	2x copay		2x copay after deductible	
Deductible, Coinsurance, and Out-of-Pocket Maximum				
Deductible - per calendar year	\$500 individual	\$1,000 individual	\$1,650 individual \$3,300 family	\$3,300 individual \$6,600 family
	\$1,000 family	\$2,000 family	The full family deductible must be met under a two–person or family contract before benefits are paid.	
Annual Employer Funding to HSA	None		\$825 for individual \$1,650 for family	
Coinsurance Amounts (Percentage)	Plan Pays 90%	Plan Pays 70%	Plan pays 100%	Plan pays 80%
	Member Pays 10% (most services)	Member Pays 30% (most services)	Member pays 0% *After deductible	Member pays 20% *After deductible
Coinsurance Maximum (per calendar year)	\$1,000 individual \$2,000 family	\$2,000 individual \$4,000 family	None	None
Annual Out-of-Pocket Maximum <i>Includes deductible, flat-dollar copays (medical and prescription) and coinsurance combined. Once met, plan pays 100% for all services.</i>	\$6,350 individual \$12,700 family	\$12,700 individual \$25,400 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>





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.

Retail 90 & Mail Order Programs

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

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

The Plan also offers a convenient and cost-saving prescription drug program for long-term maintenance medication through OptumRx. **By using the OptumRx Mail Order Prescription Drug (MOPD) program, you pay two copayments for a 90-day supply of maintenance medication under the plan.** To participate, have your doctor write you a 90-day prescription, then mail an enrollment form or complete the **BCBSMRX1 mail order drug form** at www.bcbsm.com, or call 800-841-5409. Your order will be sent to your home via UPS or First Class Mail. Reorder information will be included in your prescription shipment.

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

BCBSM—Mandatory Generic Program

The mandatory generic program requires that prescriptions be filled 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, member will pay the generic copay.
- If you request the brand drug, you will pay the brand copay and cost difference between brand and generic drugs.
- If the doctor writes "Dispense as Written" (DAW) on the prescription, the pharmacy will dispense the brand drug and you will pay the brand copay and cost difference between brand and generic drugs.



Prescription Drugs



High-Cost Drug Discount Optimization Program: Powered by PillarRx

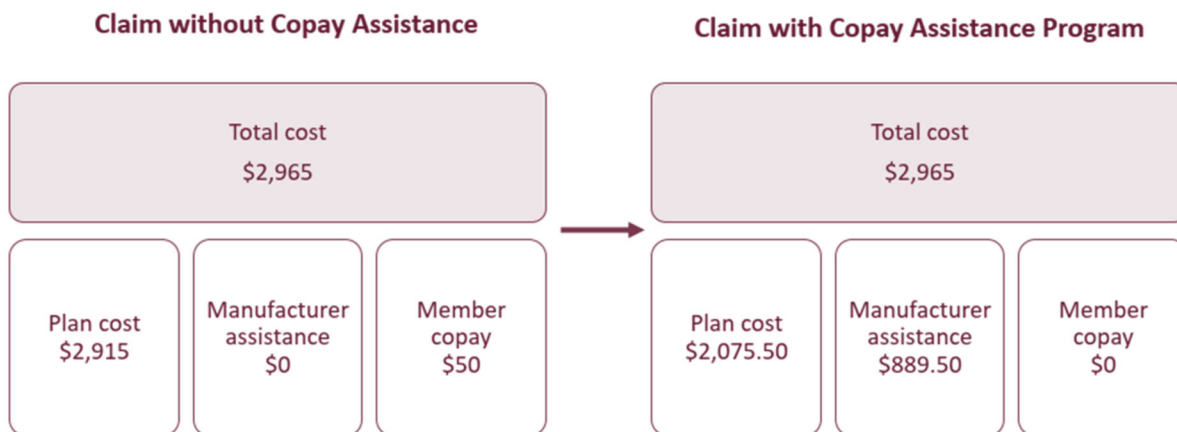
The PillarRx program will be in place for the BCBSM-PPO plan only. The HDHP with HSA is not included in the program. BCBSM will be mailing letters to those enrolled in the BCBSM-PPO plan who will be impacted.

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



The quality care
you need with the
convenience you
want

Get 24/7 care with
telemedicine



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

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

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

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	\$1,700	\$1,700
Individual Lifetime Maximum for Class IV Services	\$1,700	\$1,700
Class I—Preventive Services	100% covered	100% covered
Class II—Restorative Services	80% covered	80% covered
Class III—Major Services	60% covered	60% covered
Class IV—Orthodontic Services	60% covered	60% covered
Important Notes		
- Members who go to nonparticipating dentists are responsible for any difference between BCBSM approved amount and the dentist's charges. - For non-urgent, complex or expensive dental treatment such as crowns, bridges, or dentures, members should encourage their dentist to submit the claim to BCBSM for predetermination before treatment begins.		

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



Vision

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

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

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

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

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

Simply mail the itemized receipt to:

Heritage Vision Plans, Inc.
One Woodward Avenue, Suite 2020
Detroit, MI 48226

or email: eligibility@heritagevisionplans.com

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



Flexible Spending Accounts

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

How Do Flexible Spending Accounts Work?

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

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

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

	HCRA	DCRA
Account Purpose	To pay for eligible medical, prescription drug, dental, vision and hearing expenses not covered by another health plan.	To pay for eligible child care and dependent care expenses that allow you (and your spouse, if applicable) to work or attend school full-time
Maximum Annual Contribution per Plan Year (<i>January 1—December 31</i>)	\$3,300	\$5,000, or \$2,500 if married and filing separate tax returns
Access to Funds	You have immediate access to your entire HCRA election as of January 1. You may be reimbursed up to your annual election amount at any point during the plan year, even if you have not yet contributed that amount to your FSA via payroll deductions.	You can only be reimbursed up to the balance you currently have in your DCRA.
Examples of ELIGIBLE Expenses	◆ Deductible and coinsurance amounts ◆ Office visit and ER copayments ◆ Prescription drug copayments ◆ Hearing aids ◆ Dental treatment and orthodontia ◆ Eyeglasses and contact lenses ◆ Contact lens cleaning supplies ◆ Laser vision correction surgery	◆ After-school care ◆ Child daycare center ◆ Day camp ◆ Elder care ◆ In-home care (such as a nanny or babysitter)



Flexible Spending Accounts, continued

	HCRA	DCRA
Examples of INELIGIBLE Expenses	◆ Over-the-counter drugs for which you do not have a prescription ◆ Vitamin supplements and herbal remedies ◆ Cosmetic surgery and procedures ◆ Teeth bleaching/whitening ◆ Gym/health club dues ◆ Diapers/diaper service ◆ Insurance premiums	◆ Overnight camp ◆ Music lessons ◆ Nursing home ◆ Amounts paid to your spouse, or to your dependent child under age 19 ◆ Expenses for future services
Debit Card	Use your VISA debit card to pay for eligible health items and services at the point of sale. This card can be used only at <u>eligible locations</u> where it is accepted. This may include medical and dental providers, pharmacies and vision centers. It also includes stores, such as Target, CVS and Wal-Mart, which have an IRS-approved inventory system in place that can identify FSA-qualified items. BASIC may ask you to provide substantiation whenever you use the debit card. Please keep all documentation related to your FSA claims, such as itemized receipts and Explanations of Benefits from BCBSM. If you do not respond back to BASIC's request in a timely manner, your debit card will be suspended from use until you either provide substantiation or repay the debited amount.	The debit card is not available for use with this account. You must submit manual claims for reimbursement from your DCRA.
Manual Reimbursement of FSA Claims	Submit within the Online Portal Website: Go to the Online Portal Website (https://cda.basiconline.com/login) and login. Please remember your submission is not considered a claim until the required documentation is received. Claims need to be submitted prior to your plans final filing date (filing deadlines apply). You will be reimbursed via direct deposit (you must sign up for direct deposit separately). Please obtain a direct deposit form from HR to set up direct deposit.	Submit within the Online Portal Website: Go to the Online Portal Website (https://cda.basiconline.com/login) and login. Please remember your submission is not considered a claim until the required documentation is received. Claims need to be submitted prior to your plans final filing date (filing deadlines apply). You will be reimbursed via direct deposit (you must sign up for direct deposit separately). Please obtain a direct deposit form from HR to set up direct deposit.
Grace Period	For the 2025 plan year—Claims may be incurred until March 15, 2026 for reimbursement under the 2025 Plan Year.	For the 2025 plan year—Claims may be incurred until March 15, 2026 for reimbursement under the 2025 Plan Year.



Flexible Spending Accounts, continued

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

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

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



Basic Life/AD&D

The District provides a Basic Life and AD&D benefit of:

- If you work 25+ hours per week and/or enroll in medical—\$25,000
- If you work 30+ hours per week and do not enroll in medical—\$75,000
- If you work 10-25 hours per week—\$20,000

Rochester Community Schools pays the full cost for this coverage. Accidental Death and Dismemberment (AD&D) insurance pays an additional benefit if your death is a result of an accident. You may also receive a portion of the benefit for other losses (limb, eyesight, etc.) if the loss is a direct result of an accident. Your coverage is insured by **The Standard**.

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

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

Optional Life/AD&D

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

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.

*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.

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

Notice of Continuation Rights

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

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



Additional Services

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 AdvocateSM 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 beneficiaries² 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, continued



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 remains³



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



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.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

SI 14684

Travel Assistance EE
(6/20)

Sick Bank & Disability

Sick Bank

The first thirty (30) work days of illness or disability will not be covered by the Bank, but must be covered by the bargaining unit member's own accumulated sick leave or absence without pay. To apply for benefits from the Bank, a bargaining unit member must be non-probationary. While drawing sick leave benefits, a bargaining unit member cannot be receiving any other pay from the Board.

A maximum of sixty (60) days each fiscal year can be drawn by a bargaining unit member from the Bank. If the member is still out from the same illness at the beginning of the next fiscal year and has exceeded the sixty (60) days, he/she may draw an additional thirty (30) days for a total not to exceed ninety (90) days.

Employees who have received days from the bank and are subsequently granted Worker's Compensation benefits shall be obligated to replace (repay) sick days used from the Bank.

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

A bargaining unit member with two (2) years of seniority drawing from the Bank will received 3/4 (75%) of his/her regular, hourly, daily rate. Bargaining unit members with less than two (2) years of seniority will not qualify to draw from the sick bank.



Long-Term Disability

We offer a Long Term Disability (LTD) plan to provide income to all regular full-time employees who are disabled for an extended period of time. 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 \$1,000
Elimination Period	364 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 <i>any</i> occupation which you are qualified by education, training or experience.
Pre-existing Conditions	Benefits aren't payable for a disability that is caused by, or contributed to by a pre-existing condition, if the disability starts before the end of your first twelve months of coverage. A sickness or injury is pre-existing if, during the three months before your coverage effective date, you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines.





Rochester Community Schools

Are you aware of your 403(b) benefit?

THE OPPORTUNITY

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

We recommend 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 further 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



Employee Assistance Program

An Employee Assistance Program (EAP) provides access to assistance and services that are available to aid in managing work, family, health or other personal issues. This program is provided by **HelpNet** at no cost to you! When you or your family members need helpful guidance, counseling, local resources or reliable professional care, the EAP program is just a phone call or click away. Services are available on a live basis 24/7, and your use of this service and **the information you share is confidential**, except when your safety or the safety of another individual may be at risk or as required by law. Here are just some of the services you may receive:

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

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

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

(800) 969-6162

or

(269) 660-3900

or log on to:

www.helpneteap.com

User id: rcs

Password: employee

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



Family & Medical Leave of Absences

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

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

- Birth of employee's child and to care for newborn child;
- Placement of a child with employee for adoption or foster care;
- To care for spouse, child or parent who has a serious health condition;
- When the employee's own serious health condition renders the employee incapable 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
- You have exhausted your FMLA leave entitlement in the applicable 12 month period

Step 5: Staff member's return from Leave of Absence

All employees are required to submit a "release to work" from their health care provider. This doctor's note needs to be submitted to the HR Benefits Department prior to the employee's first day back to work.

Paperwork and information is available on the RCS employee website.

<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 - Assistant Superintendent of HR at 248-726-3118 or DMurphy@rochester.k12.mi.us.



Legal Notices

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.

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).



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



Legal Notices

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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/la hipp 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: HHSHIPPPProgram@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://dhcnp.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



Legal Notices

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 Rlte 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



Legal Notices

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

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 - Assistant Superintendent of HR at 248-726-3118 or DMurphy@rochester.k12.mi.us.



Legal Notices

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.



Legal Notices

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

You should also know that if you drop or lose your current coverage with 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 HR
Office Address:	52585 Dequindre, Rochester MI 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 (BCBSM) Dental		General info / finding a provider	(888) 826-8152 www.bcbsm.com/bluedental
Blue Cross Blue Shield of Michigan (BCBSM) Vision		General info / finding a provider	(866) 852-8947 http://www.heritagevisionplans.com/
BASIC Flexible Spending Accounts		Claim and service questions	(800) 444-1922 https://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.403bwhyhyme.com

