Birmingham
PUBLIC SCHOOLS





# Birmingham Public Schools

# 2027 Enrollment Guide







# Open Enrollment for 2027

## October 26-November 6, 2026

Now is the time to review your benefit needs for the upcoming plan year. Any changes you make to your benefit elections and dependent coverage will be effective from January 1, 2027 through December 31, 2027. This includes:

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

Understanding your benefit options is key to making the right decisions. Take some time to carefully review this Benefit Guide.

### Changes for 2027

- MESSA medical and prescription drug plan offerings
- Vision coverage will be provided by NVA
- Dental coverage will be provided by ADN

### What You Need To Do

- Review this 2027 Benefit Guide and Summary of Benefits and Coverage documents.
- Choose the benefits that are best for you and your family for January 1, 2027.
- Login to your MyMESSA at https://secure.messa.org
- Follow instructions to complete your open enrollment
- ALL EMPLOYEES ARE REQUIRED TO ENROLL THIS YEAR EVEN IF THERE ARE NO CHANGES

**All election changes must be made by November 6, 2026**

# Dependent Eligibility

## Eligibility criteria for adult children age 19 and older

Many employers follow the guidelines below. However, based on bargained contracts and employer policies, guidelines for your group may be different. Check with your employer for specific guidelines that govern your overage dependent coverage.

### Dependent adult child, age 19-26

A dependent adult child age 19-26 is eligible for medical, dental, vision and supplemental indemnity coverage until the end of the calendar year in which they turn 26. The following criteria must be met:

- You must provide the majority of the child's financial support
- Your child cannot be married

#### Coverage may continue past the age of 26 for your dependent adult child for the following situations:

A dependent adult child may continue medical, dental, vision and supplemental indemnity coverage if they have a **severe physical or intellectual impairment** which makes them incapable of self-sustaining employment.

Note: mental illness is not considered a cause of incapacity and therefore is not a basis for continued coverage.

A dependent adult child may continue medical, dental and vision coverage if they are a **full-time student** and also meet the following additional criteria:

- Attend an accredited higher-education institution and carry 12 undergraduate or 6 graduate credits
- Your child has had continuous health coverage

### Non-dependent adult child, age 19-26

Under the Affordable Care Act, adult, non-dependent children age 19-26 are eligible to continue medical cover- age until the end of the calendar year in which they turn 26. Supplement indemnity coverage may also continue until the end of the calendar year in which the non-dependent child turns 26.

- The child does not need to be dependent on you for support
- The child does not need to live with you
- The child can be married
- The child does not need to be a full-time student

# Qualified Changes in Status

## Changing your Pre-Tax Contribution Amount Mid-Year

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 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% 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 Plan Options

Birmingham Public Schools offers the following medical plan options.
All plans include 5-Tier Rx:

- **MESSA ABC Plan 2 — $2,000/$4,000, 0% coinsurance**
- **MESSA ABC Plan 2.5 — $2,550/$5,100, 0% coinsurance**
- **MESSA ABC Plan 2.5 — $2,550/$5,100, 20% coinsurance**
- **MESSA ABC Plan 3 — $3,500/$7,000, 20% coinsurance**
- **Medical Opt-Out**

## MESSA ABC Plans with HealthEquity Health Savings Account

- The Consumer Driven Health Plan (CDHP) works much like our other PPO 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 an in-network provider.

- HealthEquity® is the administrator of the Health Savings Account (HSA) with the MESSA ABC Plan. 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.

# Medical Coverage with Health Savings Account

## MESSA ABC Plans with HealthEquity Health Savings Account

Under MESSA ABC Plan 2 and both MESSA ABC Plan 2.5 options, the FULL family deductible must be met before claims are paid for any individual.

Under MESSA ABC Plan 3, if one member meets the individual deductible first, MESSA pays covered services for that member only; the rest of the family is covered once the family deductible is met.

### How the High Deductible Health Plan Works

1. You pay the applicable copays until you reach the **annual out-of-pocket maximums** for the year. Then the plan pays 100% for covered medical and prescription drugs. You pay nothing.
2. Once you meet the annual deductible, the plan covers 100% percent of your in-network medical services. You begin paying your fixed dollar **copays** for prescription drugs.
3. You pay the discounted cost for covered services up to the **annual deductible**. You can use the money in your HSA to satisfy the deductible.
4. The plan provides **preventive care at no cost** when you use an in-network provider

**2027 HSA Contribution Limits**
**Single: $4,500**
**Family: $9,000**
**Catch-Up (Age 55+): $1,000**

### 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.

**Health Savings Account (HSA)**
**A tax advantaged savings account that you can use to meet your deductible, pay copays, and reach your out-of-pocket maximum. Or you can save it for future health expenses.**

- An HSA is an interest bearing account that gives you a way to pay for current health care expenses (such as deductible and coinsurance) or to save for future health care expenses. An HSA is owned by you and is portable from employer to employer. The balance rolls over from year to year and may be used for future health care expenses during active employment or retirement.
- 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.
- With an HSA, you can only be reimbursed up to the amount that you have in your account. If you request a reimbursement for more than your balance, you may be charged an overdraft fee.

# Medical Coverage with Health Saving Account

## MESSA ABC Plans with HealthEquity Health Savings Account (Cont'd)

The maximum annual contributions for 2027 are $4,500 for single coverage and $9,000 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.

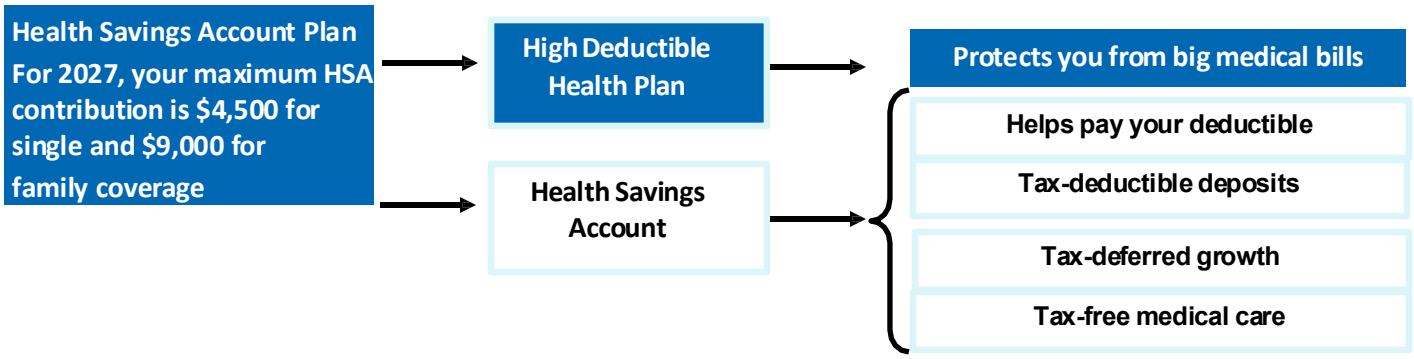
The maximum annual catch-up contribution is $1,000.

The money in your HSA can be withdrawn on a taxable basis for reasons other than a medical expense. The distribution is considered taxable income and is subject to a 20% penalty. Once you turn 65, or become disabled and/or enroll in Medicare, any distribution from your HSA for non-qualified medical expenses is considered taxable income but will not be subject to the 20% penalty.

Once you turn 65, or become disabled and/or enroll in Medicare, you can continue to use funds from your HSA. However, after age 65, you will no longer be able to contribute money to it.

It is your responsibility to report HSA activity on your tax return, including contributions to and distributions from your HSA during the year. You will need to maintain records of medical expenses.

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



# Medical Coverage with Health Savings Accoount

## MESSA ABC Plans with HealthEquity Health Savings Account

### Prorated HSA Contributions for Mid-Year Enrollments and Changes

- If you do not have HSA-compatible health coverage for an entire calendar year, you must prorate your HSA contributions to avoid tax penalties. If you join the plan midyear, you may be able to take advantage of the last month rule and contribute the entire IRS maximum for the year.
- Under the last month rule, if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year.
- You are treated as having the same HDHP coverage for the entire year as you had on the first day of that last month. However, there is a testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last month rule, you must remain an eligible individual during the testing period.
- If the employee does not satisfy the requirements of this "testing period," any contributions made the previous year (as well as any earnings made as the result of those contributions), in excess of 1/12 of the statutory maximum HSA contribution per month, must be included as income and will be subject to a 10% excise tax.

For more information:

- See IRS Publication 969 under "Contributions to an HSA".
- Review the prorated HSA contribution amounts
  listed on the Limitation Chart and Worksheet in the Instructions for IRS Form 8889, Health Savings Accounts (HSAs).
- Consult a qualified tax advisor.

### Medical Opt-Out

- If you and your dependents are covered under another group medical plan, you will be eligible for the Medical Opt-Out.
- This taxable bonus is paid in your paycheck in lieu of medical and prescription drug coverage.
- To be eligible to receive this bonus, you must complete the attestation acknowledgement, as proof of other coverage.

# Medical and Rx Plan Options

## MESSA ABC Plan 2

Effective 1/1/2027 • Birmingham Public Schools • All Eligible Employees

*In-network health care benefits for you and your covered dependents.*

| Plan feature | In-network |
|---|---|
| **Annual deductible**<br>The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31. | **Single: $2,000**<br>**2-Person & Family: $4,000**<br>When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual. |
| **Medical coinsurance**<br>A fixed percentage you pay for a medical service. | **0%** |
| **Prescription drug coverage**<br>Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. | **5-Tier Rx** |
| **Annual out-of-pocket maximums**<br>The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above the approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum. | **Single: $4,000**<br>**2-Person & Family: $8,000**<br>Out-of-pocket maximum is subject to change each Jan. 1 to align with IRS adjustments. |
| **In-network services covered at no cost to you** | |
| **Free preventive prescriptions**<br>MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more. | **No cost to you** |
| **Preventive care**<br>Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications. | **No cost to you** |
| **Prenatal and postnatal care**<br>Prenatal and postnatal doctor visits. | **No cost to you** |

All services must be medically necessary and performed by a payable provider. This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

# Medical and Rx Plan Options

## MESSA ABC Plan 2 (continued)

### In-network services subject to deductible and applicable coinsurance

- **Acupuncture** — Must be performed by an M.D. or D.O. or a registered acupuncturist.
- **Allergy testing and therapy**
- **Ambulance**
- **Autism** — applied behavior analysis (ABA) services
- **Bariatric surgery**
- **Chiropractic services including modalities** — Up to 38 visits per calendar year.
- **Diagnostic lab and X-ray**
- **Durable medical equipment (DME)**
- **Hearing aids** — There is a maximum benefit for a hearing aid for each ear during a 36-month period.
- **Hearing care** — Hearing related services performed by an M.D. or D.O.
- **Home health care**
- **Hospital emergency room (ER)**
- **Human organ transplant** — Must be performed at an approved facility.
- **Inpatient hospital**
- **Medical supplies**
- **Mental health and substance abuse** — inpatient and outpatient care
- **Office visit**
- **Osteopathic manipulations** — Performed by an Osteopathic physician. Up to 38 visits per calendar year.
- **Outpatient physical, occupational and speech therapy** — Up to a combined benefit maximum of 60 visits per individual per calendar year.
- **Prosthetics and orthotics**
- **Radiation and chemotherapy**
- **Skilled nursing facility** — Up to a maximum of 120 days per calendar year.
- **Teladoc Health visits** — 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.
- **Urgent care**

### Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Optum Rx. For more information, go to messa.org to log in to your MyMESSA account and link to the Optum Rx website. For general questions about your prescription coverage, call MESSA at 800-336-0013 or TTY 888-445-5614. For questions about a prescription order, call Optum Rx at 800-903-8346.

### Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

### Covered services and approved amounts

In-network providers bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements. Out-of-network providers may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

### Life and accidental death & dismemberment insurance

Life insurance: $5,000 policy for you. Accidental death & dismemberment insurance (AD&D): $5,000 policy for you.

*Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association. Life and AD&D insurance underwritten by Life Insurance Company of North America.*

# Medical and Rx Plan Options

## MESSA ABC Plan 2.5 with 0% coinsurance

Effective 1/1/2027 • Birmingham Public Schools • All Eligible Employees

*In-network health care benefits for you and your covered dependents.*

| Plan feature | In-network |
|---|---|
| **Annual deductible**<br>The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31. | **Single $2,550**<br>**2-Person & Family $5,100**<br>Subject to change each Jan. 1 to align with IRS adjustments.<br>When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual. |
| **Medical coinsurance**<br>A fixed percentage you pay for a medical service. | **0%** |
| **Prescription drug coverage**<br>Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. | **5-Tier Rx** |
| **Annual out-of-pocket maximums**<br>The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above the approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum. | **Single $4,550**<br>**2-Person & Family $8,700**<br>Subject to change each Jan. 1 to align with IRS adjustments. |
| **In-network services covered at no cost to you** | |
| **Free preventive prescriptions**<br>MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more. | **No cost to you** |
| **Preventive care**<br>Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications. | **No cost to you** |
| **Prenatal and postnatal care**<br>Prenatal and postnatal doctor visits. | **No cost to you** |

All services must be medically necessary and performed by a payable provider. This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

# Medical and Rx Plan Options

## MESSA ABC Plan 2.5 with 0% coinsurance (continued)

### In-network services subject to deductible and applicable coinsurance

**Acupuncture** — Must be performed by an M.D. or D.O. or a registered acupuncturist.

**Allergy testing and therapy**

**Ambulance**

**Autism** — applied behavior analysis (ABA) services

**Bariatric surgery**

**Chiropractic services including modalities** — Up to 38 visits per calendar year.

**Diagnostic lab and X-ray**

**Durable medical equipment (DME)**

**Hearing aids** — There is a maximum benefit for a hearing aid for each ear during a 36-month period.

**Hearing care** — Hearing related services performed by an M.D. or D.O.

**Home health care**

**Hospital emergency room (ER)**

**Human organ transplant** — Must be performed at an approved facility.

**Inpatient hospital**

**Medical supplies**

**Mental health and substance abuse** — inpatient and outpatient care

**Office visit**

**Osteopathic manipulations** — Performed by an Osteopathic physician. Up to 38 visits per calendar year.

**Outpatient physical, occupational and speech therapy** — Up to a combined benefit maximum of 60 visits per individual per calendar year.

**Prosthetics and orthotics**

**Radiation and chemotherapy**

**Skilled nursing facility** — Up to a maximum of 120 days per calendar year.

**Teladoc Health visits** — 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.

**Urgent care**

### Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Optum Rx. For more information, go to messa.org to log in to your MyMESSA account and link to the Optum Rx website. For general questions about your prescription coverage, call MESSA at 800-336-0013 or TTY 888-445-5614. For questions about a prescription order, call Optum Rx at 800-903-8346.

### Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

### Covered services and approved amounts

In-network providers bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements. Out-of-network providers may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

### Life and accidental death & dismemberment insurance

Life insurance: $5,000 policy for you. Accidental death & dismemberment insurance (AD&D): $5,000 policy for you.

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# Medical and Rx Plan Options

## MESSA ABC Plan 2.5 with 20% coinsurance

Effective 1/1/2027 • Birmingham Public Schools • All Eligible Employees

*In-network health care benefits for you and your covered dependents.*

| Plan feature | In-network |
|---|---|
| **Annual deductible**<br>The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31. | **Single $2,550**<br>**2-Person & Family $5,100**<br>When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.<br>*Subject to change each Jan. 1 to align with IRS adjustments.* |
| **Medical coinsurance**<br>A fixed percentage you pay for a medical service. | **20%** |
| **Prescription drug coverage**<br>Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. | **5-Tier Rx** |
| **Annual out-of-pocket maximums**<br>The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above the approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum. | **Single $5,550**<br>**2-Person & Family $8,700**<br>*Subject to change each Jan. 1 to align with IRS adjustments.* |

| In-network services covered at no cost to you | |
|---|---|
| **Free preventive prescriptions**<br>MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more. | **No cost to you** |
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# Medical and Rx Plan Options

## MESSA ABC Plan 3

Effective 1/1/2027 • Birmingham Public Schools • All Eligible Employees

*In-network health care benefits for you and your covered dependents.*

| Plan feature | In-network |
|---|---|
| **Annual deductible**<br>The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.<br>*If one member of a family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family will be paid when the family deductible has been met.* | **$3,500 individual**<br>**$7,000 family** |
| **Medical coinsurance**<br>A fixed percentage you pay for a medical service. | **20%** |
| **Prescription drug coverage**<br>Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. | **5-Tier Rx** |
| **Annual out-of-pocket maximums**<br>The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above the approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum. | **$6,500 individual**<br>**$13,000 family** |
| **In-network services covered at no cost to you** | |
| **Free preventive prescriptions**<br>MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more. | **No cost to you** |
| **Preventive care**<br>Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications. | **No cost to you** |
| **Prenatal and postnatal care**<br>Prenatal and postnatal doctor visits. | **No cost to you** |

All services must be medically necessary and performed by a payable provider. This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

# Medical and Rx Plan Options

## MESSA ABC Plan 3 (continued)

### In-network services subject to deductible and applicable coinsurance

- **Acupuncture** — Must be performed by an M.D. or D.O. or a registered acupuncturist.
- **Allergy testing and therapy**
- **Ambulance**
- **Autism** — applied behavior analysis (ABA) services
- **Bariatric surgery**
- **Chiropractic services including modalities** — Up to 38 visits per calendar year.
- **Diagnostic lab and X-ray**
- **Durable medical equipment (DME)**
- **Hearing aids** — There is a maximum benefit for a hearing aid for each ear during a 36-month period.
- **Hearing care** — Hearing related services performed by an M.D. or D.O.
- **Home health care**
- **Hospital emergency room (ER)**
- **Human organ transplant** — Must be performed at an approved facility.
- **Inpatient hospital**
- **Medical supplies**
- **Mental health and substance abuse** — inpatient and outpatient care
- **Office visit**
- **Osteopathic manipulations** — Performed by an Osteopathic physician. Up to 38 visits per calendar year.
- **Outpatient physical, occupational and speech therapy** — Up to a combined benefit maximum of 60 visits per individual per calendar year.
- **Prosthetics and orthotics**
- **Radiation and chemotherapy**
- **Skilled nursing facility** — Up to a maximum of 120 days per calendar year.
- **Teladoc Health visits** — 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.
- **Urgent care**

### Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Optum Rx. For more information, go to messa.org to log in to your MyMESSA account and link to the Optum Rx website. For general questions about your prescription coverage, call MESSA at 800-336-0013 or TTY 888-445-5614. For questions about a prescription order, call Optum Rx at 800-903-8346.

### Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

### Covered services and approved amounts

In-network providers bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements. Out-of-network providers may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

### Life and accidental death & dismemberment insurance

Life insurance: $5,000 policy for you. Accidental death & dismemberment insurance (AD&D): $5,000 policy for you.

*Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association. Life and AD&D insurance underwritten by Life Insurance Company of North America.*

# Dental Coverage

**Our dental plan is provided by ADN. The ADN plan provides access to two networks of participating dentists**

**- The ADN and Dentemax networks**

You may go to any licensed dentist, but you will save the most money if you go to a dentist who participates in one of the two networks.

Participating dentists 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.

The following employees are eligible for the ADN 100/80 plan:

- AFSCME Local #1860
- Non-exempt secretaries and clerical staff **without** other dental coverage
- Teachers
- Paraprofessionals
- Associations of Birmingham Schools and Supervisory Personnel (ABSASP) Union
- Central office administrators, exempt secretaries and operational assistants

The following employees are eligible for the ADN 50/50 plan:

- Non-exempt secretaries and clerical staff **with** other dental coverage

| Service | ADN 100/80 Plan | ADN 50/50 Plan Secretaries COB Only |
|---|---|---|
| Annual Deductible<br>Class I, II and III Services | None | None |
| Annual Benefit Maximum<br>Class I, II and III Services | $1,000 per person | $1,000 per person |
| Class I – Preventive Services | 100% coverage | 50% coverage |
| Class II—Restorative Services | 80% coverage | 50% coverage |
| Class III—Major Services | 80% coverage | 50% coverage |
| Class IV—Orthodontic Services | 80% coverage | 80% coverage |
| Lifetime Maximum—Orthodontics | $1,000 | $1,000 |

# Vision Coverage

Our vision plan is insured by National Vision Administrators (NVA).

If you are enrolled in MESSA or Opt-Out of medical coverage, you must make an election to enroll in the NVA vision plan. You get the most benefits when you receive care from a NVA provider.

Members may choose between prescription glasses (lenses and frames) or contact lenses, but not both.

| SCHEDULE OF BENEFITS | | | |
|---|---|---|---|
| **Copayments (in-network only)** | | | |
| Examination Copay | $5 | | |
| Lenses Only Copay | $7.50 | | |
| Frames | $0 | | |
| Contact Lenses | $0 | | |
| Medically Necessary Contacts Copay | $7.50 | | |
| **Benefits** | **Frequency** | **In-Network** | **Out-of-Network** |
| **Eye Examination** | | | |
| Routine Examination | Once every 12 months | Covered 100% | Up to $45 |
| **Lenses (Standard Glass or Plastic)** | | | |
| Single Vision | Once every 12 months | Covered 100% | Up to $45 |
| Bifocal | Once every 12 months | Covered 100% | Up to $65 |
| Trifocal | Once every 12 months | Covered 100% | Up to $85 |
| Lenticular | Once every 12 months | Covered 100% | Up to $100 |
| **Lens Options** | | | |
| Prisms | Once every 12 months | Covered 100% | N/A |
| **Frames** | | | |
| Retail Frame Allowance | Once every 12 months | Covered up to $130 | Up to $70 |
| 20% Discount on Frame Balance | | Yes | N/A |
| **Contact Lenses** | | | |
| **Contact Lenses** | | | In lieu of eyeglasses |
| Elective - 15% discount on Conventional / 10% discount on Disposable on remaining balance | Once every 12 months | Covered up to $125 | Up to $85 |
| Medically Necessary | Once every 12 months | Covered 100% | Up to $210 |

[1]Includes frames up to $52 every day low price-price point at Walmart/Sam's Club locations (if included in the network) and Costco. [2]Discount does not apply at Walmart/Sam's Club locations, LensCrafters or for certain proprietary frame brands or where prohibited by law. [3]Fitting & follow-up fees are deducted from the contact lens allowance shown above unless otherwise specified. [4]Prior authorization required from NVA. Includes fitting & follow-up.

# Basic Life and Accidental Death & Dismemberment

Birmingham Public Schools provides its employees Basic Life, Accidental Death & Dismemberment (AD&D) coverage. This benefit is paid by Birmingham Public Schools.

For ABSASP Members, Superintendent, Central Office Personnel, Operational Assistances and Administrative Assistants: Basic Life/AD&D benefits are based on a multiple of earnings. All other employee classes receive a flat dollar benefit as outlined the table below.

| Employee Class | Basic Life and AD&D Amount |
|---|---|
| ABSASP Members | An amount equal to two times your basic annual earnings, rounded to the nearest $1,000 to a maximum of $500,000 |
| Superintendent, Central Office Personnel, Operational Assistances and Administrative Assistants | An amount equal to three times your basic annual earnings, rounded to the nearest $1,000 to a maximum of $500,000 |
| Non-Supervisory Custodians, Maintenance & Mechanics of AFSCME Local 1860 | $45,000 |
| BEA Members | $45,000 |
| MESPA Members | $45,000 |
| MESPA Paraprofessionals | $45,000 |

For ABSASP Members, Superintendent, Central Office, Personnel, Operational Assistances and Administrative Assistants:

- Earnings are defined as base earnings not including overtime pay, bonuses, commissions, or other extra income.
- For newly hired employees, in order to be covered for greater than $300,000 of Life/AD&D benefits, you must complete the district provided Statement of Health Form and submit it to MetLife. If the evidence of good health is not approved MetLife, the amount of your Life/AD&D benefits will not be greater than $300,000.
- Current employees whose Life/AD&D benefits will exceed $300,000 due to a salary increase must complete the district provided Statement of Health Form and submit before the increased benefits will apply. If the evidence of good health is not approved, the amount of your Life/AD&D benefits will not be increased.

Life benefits reduce based on age. If you are not actively at work on the date insurance would otherwise take effect or increase, insurance will take effect on the day you resume active work. Review the carrier certificate / benefit booklet for details on these and other important provisions.

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

**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.

# Disability Coverage

## Optional Short Term Disability

We offer a Short Term Disability (STD) plan to provide income to employees who are disabled for a period of time. Full-time eligible employees have the opportunity to purchase STD through post-tax payroll deductions. This coverage is insured by MESSA.

Benefits are payable if you become disabled by accidental injury or sickness while insured and remain disabled beyond the elimination period you elect. You must be under the regular care and attendance of a physician. You may elect either a seven or twenty-eight day elimination period.

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A pre-existing condition is defined as an injury or sickness or related medical condition for which medical advice, care or treatment (including prescription drugs) was received during the three-month period ending on the effective date of coverage. In the event you have a pre- existing condition, no benefits are payable for disability for that condition. This pre-existing provision expires on the earliest of: 1) three consecutive months ending on or after the effective date of your insurance if during this time you do not incur any expenses or receive any medical treatment or services in connection with the condition; 2) six consecutive months if during this time you have been continuously insured and there has been no loss of time from active employment due to the condition; 3) twelve consecutive months if during this time you have been continuously insured.
Earnings are defined as base earnings not including overtime pay, bonuses, part-time employment, etc.
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. Review the MESSA STD booklet for these details and other important provisions.

# Disability Coverage

## Optional Short Term Disability

| SHORT TERM DISABILITY PREMIUM COST<br>Monthly Deduction Amount | | | |
|---|---|---|---|
| **Annual Salary** | **Weekly Benefit Amount** | **Deduction Amount 8th Day Waiting Period** | **Deduction Amount 29th Day Waiting Period** |
| $1,300.00 | $20.00 | $2.00 | $1.40 |
| $2,600.00 | $40.00 | $4.00 | $2.80 |
| $3,900.00 | $60.00 | $6.00 | $4.20 |
| $5,200.00 | $80.00 | $8.00 | $5.60 |
| $6,500.00 | $100.00 | $10.00 | $7.00 |
| $8,000.00 | $120.00 | $12.00 | $8.40 |
| $9,500.00 | $140.00 | $14.00 | $9.80 |
| $11,000.00 | $160.00 | $16.00 | $11.20 |
| $12,500.00 | $180.00 | $18.00 | $12.60 |
| $14,000.00 | $200.00 | $20.00 | $14.00 |
| $15,500.00 | $220.00 | $22.00 | $15.40 |
| $17,000.00 | $240.00 | $24.00 | $16.80 |
| $18,500.00 | $260.00 | $26.00 | $18.20 |
| $20,000.00 | $280.00 | $28.00 | $19.60 |
| $21,500.00 | $300.00 | $30.00 | $21.00 |
| $23,000.00 | $320.00 | $32.00 | $22.40 |
| $24,500.00 | $340.00 | $34.00 | $23.80 |
| $26,000.00 | $360.00 | $36.00 | $25.20 |
| $27,500.00 | $380.00 | $38.00 | $26.60 |
| $29,000.00 | $400.00 | $40.00 | $28.00 |
| $30,500.00 | $420.00 | $42.00 | $29.40 |
| $32,000.00 | $440.00 | $44.00 | $30.80 |
| $33,500.00 | $460.00 | $46.00 | $32.20 |
| $35,000.00 | $480.00 | $48.00 | $33.60 |
| $36,500.00 | $500.00 | $50.00 | $35.00 |
| $38,000.00 | $520.00 | $52.00 | $36.40 |
| $39,500.00 | $540.00 | $54.00 | $37.80 |
| $41,000.00 | $560.00 | $56.00 | $39.20 |
| $42,500.00 | $580.00 | $58.00 | $40.60 |
| $44,000.00 | $600.00 | $60.00 | $42.00 |
| $45,500.00 | $620.00 | $62.00 | $43.40 |
| $47,000.00 | $640.00 | $64.00 | $44.80 |
| $48,500.00 | $660.00 | $66.00 | $46.20 |
| $50,000.00 | $680.00 | $68.00 | $47.60 |
| $51,500.00 | $700.00 | $70.00 | $49.00 |

# Disability Coverage

## Long Term Disability

We offer a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time.

A disability is defined as during the elimination period and the first 24 months, the inability to perform the substantial duties of your regular occupation.
After this period, disability is the inability to perform any job that you are suited for by way of education, training, and experience.

Benefits for Non-Supervisory Custodians, Maintenance & Mechanics of AFSCME Local 1860 are payable up to age 70 or longer depending on a person's age at disability. Benefits are limited to 24 months for mental illness conditions unless hospital confined. Benefits for all other employee classes listed below are payable up to age 65 or longer depending on a person's age at disability. Benefits are limited to 24 months for mental illness conditions unless hospital confined.

A pre-existing condition is defined as a sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures or had taken prescribed drugs or medication during the time period shown in the chart below.

Benefits are not payable for a disability that is caused by, or contributed to by a pre-existing condition, if the disability starts before the time period provided in the chart below.

Earnings are defined as base earnings not including overtime pay, bonuses, commissions, or other extra income. However, ABSASP Members, earnings are defined in the union contract.

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. Review the carrier certificate / benefit booklet for details on these and other important provisions.

BEA and MESPA LTD benefits provided by MESSA.

| Employee Class | Long Term Disability Benefit | |
|---|---|---|
| | Monthly Benefit | Elimination Period |
| ABSASP Members | 66-2/3% of earnings to a maximum of $6,000 | 180 days |
| Superintendent, Central Office Personnel, Operational Assistances and Administrative Assistants | 66-2/3% of earnings to a maximum of $8,000 | 180 days |
| Non-Supervisory Custodians,Maintenance & Mechanics of AFSCME Local 1860 | 50% of earnings to a maximum of $800 | 180 days |
| MESPA Members | 66-2/3% of earnings to a maximum of $2,500 | 180 days |
| MESPA Paraprofessionals | 66-2/3% of earnings to a maximum of $1,000 | 180 days |
| BEA Members | 66-2/3% of earnings to a maximum of $5,000 | 180 days |

# Flexible Spending Accounts

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

There are two types of accounts under this plan: a Health Care Flexible Spending Account (HCFSA) and a Dependent Care Flexible Spending Account (DCFSA). Enroll in one account or both. Health Equity administers these plans for us.

With a HCFSA or DCFSA, you decide before the start of the year how much to contribute to each account. Your pre-tax contributions are withheld in equal amounts from your paychecks throughout the year. The money goes into an account(s) set up in your name. Claim the money in your account(s) by using a debit card for HCFSA expenses only or you can file a claim form for reimbursement. You may receive reimbursement by either check or direct deposit.

If you enroll in the MESSA ABC Plan, you are not eligible to participate in the Health Care Flexible Spending Account. However, you are eligible to participate in the HSA. You are also eligible to participate in a Dependent Care Flexible Spending Account.

***These accounts help you save money.***

| 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 Medical 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

## Health Care FSA

The HCFSA helps you pay for medical, dental, and vision expenses that are not covered by insurance. This includes copays, deductibles, and amounts over the annual maximum. You can put up to $3,300 into the HCFSA, minimum contribution of $100. The full amount will be available January 1st.

When you enroll in a Flexible Spending Account, you will receive a Debit Card. With one swipe, you can pay eligible expenses at the point-of-service. Payments can be deducted directly from your account and you don't have to file a claim form and wait for reimbursement.

For a complete list of the expenses eligible for reimbursement, visit the IRS website at https://www.irs.gov/pub/irs-pdf/p969.pdf.

**Flexible Spending Accounts**
**2027 Maximum Annual Contribution**

- **Health Care**: $3,400
- **Dependent Care**: $7,500

## Dependent Care FSA

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

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

You can contribute up to $7,500 into your DCFSA, minimum contribution of $100. 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 $3,750 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 $7,500.
- If your spouse is disabled or a full-time student, special limits apply.
- If you or your spouse earn less than $7,500, the maximum is limited to earnings under $7,500.

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

# Flexible Spending Accounts

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

Eligible dependent care expenses can either be reimbursed through the DCFSA or used to obtain the federal tax credit. You can't 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 IRS publication 503 at **http://www.irs.gov/publications/p503/ index.html.**

If you contribute to a Dependent Care Flexible Spending Account, 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

All claims must be incurred by December 31, 2027 for the 2027 plan year. Claims incurred prior to your enrollment in the plan are not eligible for reimbursement. All 2027 expenses must be submitted to Health Equity by March 31, 2028. You should consider submitting your expenses as they occur. This will help avoid year end processing delays.

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

Any money left in a HCFSA or DCFSA account at the end of the year has to be forfeited. People call this the "use it or lose it" rule.

This sounds scary, but don't let it keep you from enrolling in these accounts. You can avoid losing money with some planning.

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

Dependent care expenses can be budgeted ahead of time.

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

# Travel Assistance

## UNUM Worldwide Emergency Travel Assistance Services

The Unum worldwide emergency travel assistance services are available to you through Assist America Inc. When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family (limitations apply) can count on getting help in the event of a medical emergency. Emergency travel assistance includes:

- Hospital admission guarantee (limitations apply)
- Emergency medical evacuation
- Medically supervised transportation home
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Multilingual crisis management professionals
- Medical referrals to Western-trained, English- speaking medical providers
- Care and transportation of unattended minor child

For more information, contact Benefits Department or Unum at the number listed on the contact page of this Guide.

# Contact Information

| Provider | Benefit | Phone Numbers | Website |
|---|---|---|---|
| **National Vision Administrators** | Vision | (800) 672-7723 | www.e-nva.com |
| **ADN** | Dental | (888)-ADN-1100 | www.adndental.com |
| **HealthEquity** | HSA and FSA | (877) 218-3432 | www.healthequity.com |
| **MESSA** | Medical<br>Short Term Disability<br>Long Term Disability<br>Travel Assistance | (800) 336-0013 | www.messa.org |
| **MetLife** | Basic Life / AD&D | (800) 275-4638 | www.metlife.com |
| **Unum** | Long Term Disability | (866) 879-3054 | www.unum.com |
| **Unum / Assist America, Inc.** | Travel Assistance | Inside U.S.: (800) 872-1414<br>Outside U.S.: + (U.S. access code) (609) 986-1234 | www.unum.com/travelassistance |

# Required Notices

## HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact Benefits Department.

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

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

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

## Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

# Required Notices

## Women's Health and Cancer Rights Act of 1998

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

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

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

Service number on your member identification card.

## Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a postsecondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

## Protecting Your Privacy

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

## Disclosure about the Benefit Enrollment Communications

The benefit enrollment communications (the Benefit Guide, etc.) contains a general outline of covered benefits and does 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. Birmingham 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.

# Required 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, 2026. Contact your State for more information on eligibility –**

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

# Required Notices

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program<br>(KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |

# Required Notices

| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>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<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |

# Required Notices

| VERMONT– Medicaid | VIRGINIA – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |

| WASHINGTON – Medicaid | WEST VIRGINIA – Medicaid and CHIP |
|---|---|
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2026, 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

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent.

# Required Notices

## Creditable Coverage Notice

### Important Notice from Birmingham Public Schools About Your Prescription Drug Coverage and Medicare

**IMPORTANT NOTE:**

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

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

#### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

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

#### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Birmingham Public Schools coverage may be affected. For more information, please refer to the benefit plan's governing documents.

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

#### When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

1. You should also know that if you drop or lose your current coverage with Birmingham 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

# Required Notices

## Important Notice from Birmingham Public Schools About Your Prescription Drug Coverage and Medicare (Cont'd)

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 Birmingham Public 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: | October 15, 2025 |
| Name of Entity/Sender: | Birmingham Public Schools |
| Contact—Position/Office: | Benefits Department |
| Address: | 31301 Evergreen Road, Beverly Hills, MI 48025 |
| Phone Number: | 248-203-3098 |




This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.