EASTPOINTE
COMMUNITY SCHOOLS

2025 Benefit Guide

Local 120

Head Cooks

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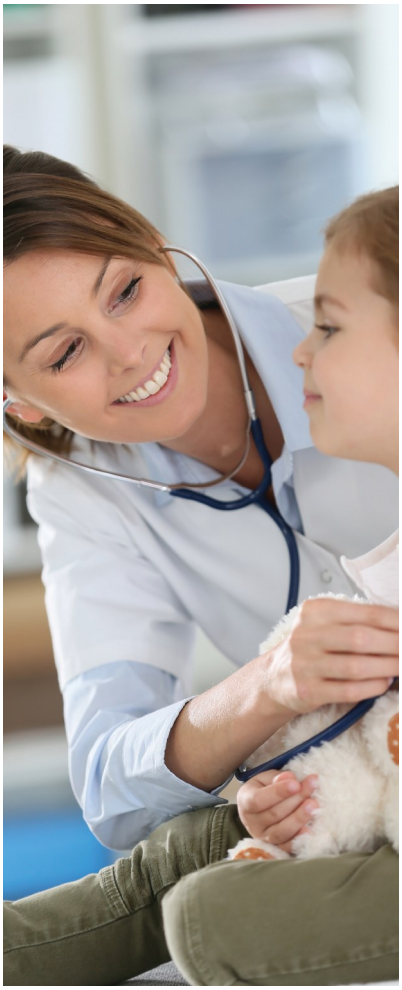
Information about Medicare

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 Creditable Coverage Notice on pages 39-40 for details.

2025 Benefit Guide



Eastpointe Community Schools offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This Benefit Guide will provide an overview of the benefit plans that Eastpointe Community Schools sponsors. This is your opportunity to enroll and/or change your benefit elections. 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).

After reviewing this Benefit Guide, you will need to make a decision about the benefits you want to elect for 2025.

How to Enroll

- Review the benefits detailed in this Benefit Guide.
- Review and make your benefit elections on the 2025 Benefit Election Form.
- Return the 2025 Benefit Election Form to Human Resources by **November 22nd**
- You will not be able to change your benefit elections until the next open enrollment period unless you have a qualified change in status.

Making Mid-Year Changes

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

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

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

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

Employee Contributions

Your contributions for coverage will be deducted from your paycheck on a pre-tax basis in the plan year. **There is no cost to enroll in the Core dental plan.**

Eastpointe Community Schools has a Section 125 Premium Conversion Plan. Contributions taken on a pre-tax basis are NOT subject to federal, state, and FICA taxes. As a result, your net contributions will be less due to the pre-tax savings under the Section 125 Premium Conversion Plan. The amount of savings will vary depending on your individual contribution and income tax bracket. Additionally, pre-tax contributions will slightly impact your social security contributions.

Monthly payroll deductions for 2025 are shown in the chart below.

Employee Monthly Contributions			
Coverage	**Single**	**Two Person**	**Family**
Medical PPO	$168.37	$400.45	$500.99
Dental Core	$0.00	$0.00	$0.00
Dental Buy-Up	$21.12	$45.80	$63.33
Vision Core	$1.78	$1.78	$1.78
Vision Buy-Up	$3.85	$5.71	$7.81

Medical/Prescription Drugs

Eastpointe Community Schools offers a Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization medical/prescription drug plan. Eastpointe Community Schools and you both contribute toward the cost for medical/prescription drug coverage.

The Blue Cross Blue Shield of Michigan medical plan is "self-funded". This means that each medical claim is paid directly by Eastpointe 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, Eastpointe Community Schools 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.

Blue Cross Blue Shield of Michigan—PPO

- Our Blue Cross Blue Shield of Michigan (BCBSM) PPO plan provides comprehensive coverage. "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 the BCBSM website.
- You get the most benefits when you receive care from PPO providers. 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 visit a non-PPO provider, it will be in your financial interest to receive care from a BCBSM participating provider. That's because the participating provider must accept BCBSM's approved amount—they can't balance bill you for more than your deductible and coinsurance. A non- participating provider can balance bill you whatever amount s/he thinks is fair–there's no limit to what you can be charged.
- Coverage at non-participating hospitals (those who do not participate with BCBSM) is limited to services needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital services or services received at mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

Managing your health plan online has never been easier.
With the new member site, you have access to:

- **Personal snapshot of your benefits**
- **Single user ID for life**
- **Find doctors and hospitals**
- **Evaluate doctors and hospitals for quality and cost**
- **Helpful patients reviews**
- **Virtual ID card**

Register now at www.bcbsm.com (You'll need your BCBSM ID card)

Medical/Prescription Drugs

Prescriptions Drugs

The BCBSM medical plan include prescription drug coverage.

The BCBSM formulary is a continually updated list of Federal Drug Administration approved medications that represent each therapeutic class of drugs. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. You may access the formulary listing on the BCBSM website.

This formulary listing designates requirements, including Prior Authorization and Step-Therapy, that must be followed in order to obtain a specific medication. Prior Authorization and Step-Therapy monitor certain medications to ensure that covered individuals receive the most appropriate and cost-effective drug therapy. Both of these are explained below.

Prior Authorization

Certain prescription drugs require prior authorization (prior approval), which means that your provider will need to contact BCBSM before you fill your prescription. If BCBSM does not get the necessary information to satisfy the prior authorization, BCBSM may not cover the drug. Drugs selected include those with a potential for alternative use or misuse (for example, growth hormones).

Step Therapy

In some cases, BCBSM requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, BCBSM may require your doctor to prescribe Drug A first. If Drug A does not work for you, then BCBSM will cover Drug B.

The *Prior Authorization/Step Therapy Drug List* details the prescriptions which fall under this provision and the criteria for each prescription. You can find the *Prior Authorization/ Step Therapy Drug List* at www.bcbsm.com. Click on "I am a Member," then click on "Prescription Drugs."

If OptumRx informs you your doctor failed to get Prior Authorization, you can contact your physician's office right from the pharmacy and remind them to call the Pharmacy Clinical help desk at (800) 437-3803. This will reduce waiting time in the pharmacy on your part and prevent you from paying out-of-pocket for medications that should be covered as a part of your prescription program.

Specialty Prescription Program

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 but not limited to:

- Asthma
- Cancer
- Chronic Kidney Failure
- Hepatitis C
- HIV/AIDS
- Rheumatoid Arthritis
- Infertility
- Multiple Sclerosis
- Organ Transplants
- Osteoporosis
- Psoriasis

If your medication is included in the specialty drug list, you can get your prescription drugs delivered to your home by mail ordering them through AllianceRx Walgreens Prime. For more information, please call AllianceRx Walgreens Prime Customer Service at 1-866-515-1355 or visit alliancerxwp.com. You may also fill your prescription at a retail pharmacy, but not all pharmacies dispense specialty drugs, so call your pharmacy to verify if they can fill your prescription.

Medical/Prescription Drugs

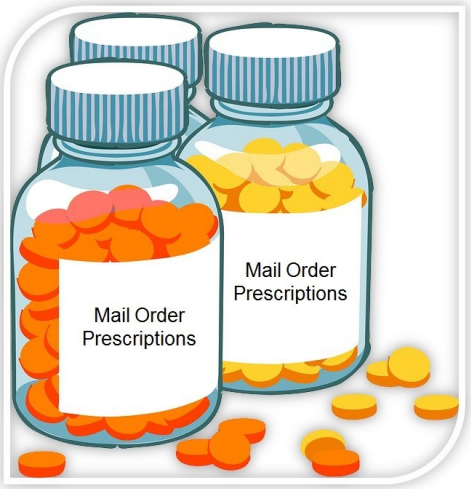
Retail 90 & Mail Order Programs

This program allows you to receive a 90-day prescription refill for maintenance medication from participating walk-in pharmacies for one copayment. 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 BCBSM 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 one copayment for a 90-day supply of maintenance medication under the plan.

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.



Medical/Prescription Drugs

Medical Plan and Coordination

In Michigan, you have the choice between two types of medical benefit options on an auto insurance policy:

- Non-Coordinated Coverage (Auto Insurance pays primary)
- Coordinated Coverage (Auto Insurance pays secondary)

It is important to understand the medical coverage election on your auto insurance coverage. Whether your auto coverage is coordinated or non-coordinated is typically determined by how the medical plan coordinates with auto insurance. Auto insurers may give members a discount if their medical plan pays primary to auto insurance or may increase your auto premiums if your medical plan pays secondary to the auto insurance.

If you receive a letter from your auto insurance carrier asking you to verify that your health insurer is the primary payer (Coordinated), you will need to take the following steps:

- BCBSM plans will generally be primary to your no-fault auto insurance
- Call the Customer Service number listed on the back of your medical ID card to obtain this information

Selecting automobile insurance coverage can get complicated and should be discussed with an auto insurer/ agent. There are many different accident scenarios that come into play in determining how auto insurance will pay/coordinate with a group medical plan. It can be very difficult to ascertain which plan will pay primary versus secondary for every situation.

Blue Cross Blue Shield Telemedicine

As a member of Blue Cross Blue Shield of Michigan, you have the ability to access quality health care anytime, anywhere.

With Virtual Care by Teladoc Health, you can get fast, convenient, affordable (same cost as your office visit copay) online health care 24 hours a day, seven days a week, whenever you are in the U.S.

Why Should I Use It?

- Your primary care doctor is not available
- You cannot leave your home or work
- You are on vacation or traveling for work
- You are caring for children or a family member and cannot leave home, or
- You are looking for affordable after-hours care

Who Can Use It?

Family members on your plan can also use Virtual Care by Teladoc Health. You must add your spouse and children to your account so it is ready when they need to use it.

When Should I Use It?

Virtual Care by Teladoc Health is not for every medical condition; however below are a few common conditions an online visit can treat:

- sinus or respiratory infection
- cold, flu, or seasonal allergies
- urinary tract infection
- vomiting, diarrhea, headache, strains and sprains, pinkeye, or skin rash
- Behavioral health needs such as anxiety, depression, grief, etc (require an appointment)

To access visit bcbsm.com/virtualcare for a link to download the Teladoc Health App. You can also open the Blue Cross Blue Shield of Michigan mobile app, click Find Care and then Virtual Care.

You will need your Blue Cross member ID card to access.

Medical/Prescription Drugs

	In-Network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	$250 for one member $500 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$500 for one member $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for online visits • $20 copay for chiropractic services and osteopathic manipulative therapy • $250 copay for emergency room visits • $20 copay for urgent care visits	$100 copay for emergency room visits
Coinsurance Amounts (percent copays) **Note**: the coinsurance amounts apply once the deductible has been met	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums – applies to coinsurance amounts for all covered services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 for one member $2,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost -sharing amounts for prescription drugs, if applicable	$6,350 for one member $12,700 or the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member $25,400 or the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Medical/Prescription Drugs

	In-Network	Out-of-Network
Preventive Care Services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screen and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and childcare visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Medical/Prescription Drugs

	In-Network	Out-of-Network
Physician Office Services		
Office visits – must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits – by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible
Emergency Medical Care		
Hospital emergency room	$250 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic Services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity Services—provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
Hospital Care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies. **Note**: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible Unlimited Days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Medical/Prescription Drugs

	In-Network	Out-of-Network
Alternatives to Hospital Care		
Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible
Surgical Services		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see "**Preventive care services**."	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible
Human Organ Transplants		
Specified human organ transplants – must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Medical/Prescription Drugs

	In-Network	Out-of-Network
Mental Health Care and Substance Use Disorder Treatment		
Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.		
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic • Physician's office	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**
	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment – in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

BCBSM—Save money and live healthier with Blue365

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

Member discounts with Blue365 offers exclusive deals on things like:

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

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

Medical/Prescription Drugs

	In-Network	Out-of-Network
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered
Other Covered Services		
Outpatient Diabetes Management Program (ODMP) **Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost- sharing when rendered by an in-network provider. **Note**: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/ coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Prescription Drugs		
Retail (up to a 30 day supply)	$7 Generic $35 Formulary $70 Non-Formulary Brand	Prescriptions reimbursed at 75% of approved amount less in-network copays
Mail-Order (Up to a 90-day supply)	$7 Generic $35 Formulary Brand $70 Non-Formulary Brand	Not Covered

Note: The BCBSM medical/Rx Summary of Benefits and Coverage (SBC) is located on the Eastpointe Community Schools District website: Link to website: https://dashboard.eidexinsights.com/Eastpointe-Community-Schools

MIBlue Virtual Assistant

When you need info about your plan fast – MIBlue Virtual Assistant is at your service

Sometimes you need quick answers to questions about your plan. What is covered under my plan? What is my copay? How do I find a doctor in my plan's network?

Ask MIBlue Virtual Assistant.

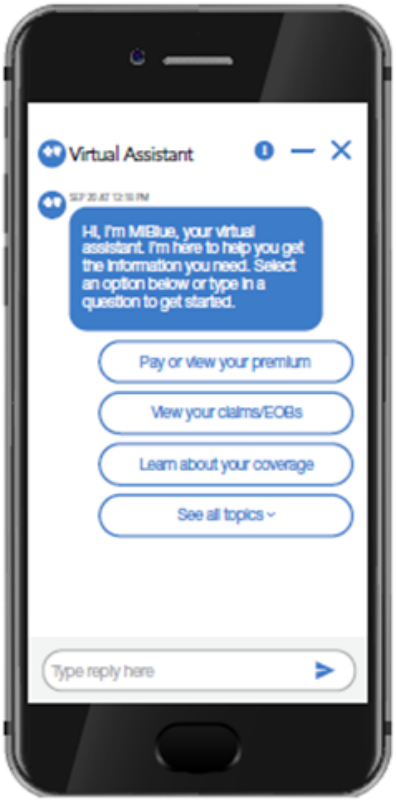
MIBlue Virtual Assistant is an interactive, automated chat feature available through your online Blue Cross member account. It provides immediate 24/7 support, so you can find the plan information you need.

Here's what it can do

Log in to your online account, or use our app, and select the Virtual Assistant icon in the upper right corner of your screen.

MIBlue Virtual Assistant is ready to help you:

- Check your coverage.
- Find options for care.
- Search for doctors and hospitals.
- Look up your copay, deductible and other balances.
- Find a certain claim or referral.



You can even use MIBlue Virtual Assistant to order another member ID card and update your paperless options.

No office hours. No waiting. No problem.

Log in to your account today — and introduce yourself to MIBlue Virtual Assistant.

Dental

Our dental plan is self-funded and administered by ADN Administrators Inc. Eastpointe Community Schools pays the full cost for dental coverage. If you enroll in medical coverage, you will be enrolled in dental coverage.

ADN Administrators utilizes two Preferred Provider Organization (PPO) networks—ADN Dental Network and Dentemax. Our dental plan allows freedom of choice, you may receive treatment from any licensed dentist or dental specialist. However, utilization of a PPO dental provider will substantially reduce your out-of-pocket dental expenses and overall dental benefit costs. Participating PPO dentists will adhere to ADN's processing policies and are prohibited from billing a patient above the pre-negotiated fee, accepting billing under these terms as payment in full and there are no claim forms to submit for reimbursement.

Non-participating dentists may not agree to bill ADN directly. If your dentist requires you to pay out-of-pocket, request that he/she submit the claim for your reimbursement. They may either submit the claim or give it to the patient for submission. ADN can issue benefit payment directly to you.

Special Note: If your spouse is an employee of the district, you will both be enrolled in the Buy-Down Plan.

Plan Year: January 1 through December 31	Core Plan In-Network Benefits	Buy-Up Plan In-Network Benefits
Maximum Benefits		
Annual Maximum—per eligible individual for covered Class I, II and III services	$1,500	$1,500
Class I—Preventative Services		
Oral Examinations—Twice per plan year Bitewing X-Rays—Once per plan year Prophylaxis (Cleaning)—Twice per plan year Topical Application of Fluoride—Twice per plan year to age 19 Full-Mouth Series or Panoramic X-Rays—Once per 60 months All Other X-Rays Space Maintainers—Once per area per lifetime, up to age 19	80% coverage	100% coverage
Class II—Restorative Services		
Periodontal Maintenance—Twice per plan year Composite & Amalgam fillings**—Once per tooth surface per 12 months Root Canal therapy Periodontal Root Planing—Once per quadrant per 24 months Periodontal Surgery—Once per quadrant per 36 months Oral Surgery & Extractions General Anesthesia or IV Sedation—Medically necessary & with covered oral surgery Denture Repair and Adjustment Denture Reline or Rebase—Once per 36 months, per arch	80% coverage	100% coverage
Class III—Major Services		
Inlays, Onlays, Crowns**—Once per permanent tooth in 60 months Complete & Partial Removable Dentures**—Once per arch per 60 months Fixed Partial Dentures (Bridges)**—Once per arch per 60 months Addition of Teeth to Partial Dentures	80% coverage	80% coverage
Class IV—Orthodontia		
Up to the age of 19—Lifetime maximum of $1,000	Not covered	50% coverage
Services Not Covered		
Sealants Implants & Restoration over implants TMJ/TMD Treatment Occlusal Guards	Deductible—None Missing Tooth Clause—None 12 Month Billing Limitation Waiting Periods—None Coordination of Benefits—Standard	

** Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies ** Prosthetics are considered on seat/delivery date

****Note—Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitations. Predetermination is strongly encouraged for all non–emergency dental treatment exceeding $250 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

Vision

Our vision coverage is insured by National Vision Administrators (NVA). Per our Group Policy, all employees are enrolled in vision coverage.

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering: paid-in-full eye examination and eyeglasses. Frame Collection: Your plan includes a selection of name brand frames that are completely covered in full.

You will receive the maximum benefits when you receive care from an in-network provider. If you choose to receive care from an out-of-network provider, you will pay more out-of-pocket because out-of-network providers can charge whatever amount they think is fair for the service they provide.

Vision Services	Core Plan In-Network	Buy-Up Plan In-Network
Exam—Once Every 12 Months		
Eye Exam	100% of approved amount Once every 12 months	100% of approved amount Once every 12 months
Frames		
Frames	$68 allowance Once every 24 months	$125 allowance Once every 24 months
Lenses		
Standard (Includes single, bifocal, trifocal and lenticular)	100% of approved amount Once every 24 months	100% of approved amount Once every 12 months
Contact Lenses		
Elective Contacts	$150 allowance Once every 24 months Includes15% off discount after benefit has been exhausted	$150 allowance Once every 12 months Includes 10% off discount after benefit has been exhausted

To find an NVA participating provider, please visit: e-nva.com or call 800.672.7723

Life and AD&D

Basic Life and Accidental Death and Dismemberment

Eastpointe Community Schools provides full-time employees with Basic Life and AD&D insurance, insured by Mutual of Omaha, and pays the full cost of this benefit.

Life insurance is extremely important if you have family members that depend on your income. Life insurance provides financial security for you and your dependents should you die while an employee of this district. Accidental Death and Dismemberment (AD&D) insurance pays an additional benefit if your death is a result of an accident. In addition, AD&D insurance will pay a portion of the benefit for a loss of limb, eyesight or both, if the loss is a direct result of an accident.

Review the Union Contract and certificate/booklet for your Basic Life and AD&D benefit amount further coverage details.

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.

Optional Life and Accidental Death and Dismemberment

Employees who want to supplement their group life insurance benefits may purchase additional coverage through Mutual of Omaha. When you enroll yourself in this benefit, you pay the full cost through pre-tax payroll deductions.

- You can elect coverage for yourself in increments of $10,000 to a maximum of five times your annual salary, up to $150,000.
- You can elect coverage for your dependent spouse in increments of $5,000 to a maximum of 100% of your elected benefit.
- You can elect coverage for your dependent child(ren) in increments of $1,000 starting at $2,000 to a maximum of $10,000.

Dependent spouse and/or child(ren) coverage is only available if the employee has coverage under this plan. Spouse coverage terminates at age 70.

Evidence of insurability is required if you waive coverage when you are initially eligible and choose to enroll at a later date; and for any increase in coverage. Benefits reduce at age 70 for employee coverage, spousal coverage terminates at age 70. Coverage effective dates and increases in coverage may be delayed if you are disabled or have a life threatening condition on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.

Optional Life/AD&D Rates Employee/Spouse		
Age	Monthly Life Rate per $1,000 of Coverage	Monthly AD&D Rate per $1,000 of Coverage
<25	$0.070	$0.025
25-29	$0.070	$0.025
30-34	$0.090	$0.025
35-39	$0.090	$0.025
40-44	$0.140	$0.025
45-49	$0.210	$0.025
50-54	$0.340	$0.025
55-59	$0.510	$0.025
60-64	$0.580	$0.025
65-69	$0.960	$0.025
70 +	$1.68	$0.025

Dependent child(ren) rate is $0.11 for Voluntary Life and $0.040 for Voluntary AD&D per $1,000 of coverage

Calculate your monthly cost by dividing your election amount by 1,000, then multiply by the rate in the chart above this amount equals your monthly cost. (Example based on age 35: $35,000 ÷ 1,000 = 35 x $0.115 = $4.03 monthly cost)

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.

Flexible Spending Accounts

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

There are two types of accounts under this plan: a Health Care Reimbursement Account (HCRA) and a Dependent Care Reimbursement Account (DCRA). Enroll in one account or both. Employee Benefit Concepts, Inc. (EBC) administers the plan for us.

Flexible Spending Accounts 2025 Maximum Annual Contribution

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

With a HCRA or DCRA, you decide before the start of the year how much to contribute to each account. Your 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 HCRA claims only or you can file a claim form for reimbursement. You must enroll/re-enroll in the plan to participate for the plan year January 1 to December 31, 2025.

How the Accounts Save You Money	Without a HCRA or DCRA	With a HCRA or DCRA
Gross Salary	$25,000	$25,000
Less Annual Amount Deposited into HCRA / DCRA	$0	($2,000)
Taxable Income	$25,000	$23,000
Less Annual Taxes (assumed at 25%)	($6,250)	($5,750)
Net Salary	$18,750	$17,250
Less Out-of-Pocket Health Care and/or Dependent Care Expenses for the Year	($2,000)	N/A
Disposable Income	$16,750	$17,250
Tax Savings	None	$500

Health Care Reimbursement Account (HCRA)

The HCRA helps you pay for medical, dental, and vision bills that are not covered by insurance. You can put up to $3,300 into the HCRA in 2025. The full amount will be available January 1, 2025.

When you enroll in the HCRA, you will receive a debit card—with one swipe, you can pay eligible expenses at the point-of-service. Just use the card like you would a credit card. Other advantages of the debit card:

- It deducts payments directly from your account.
- You don't have to file claim forms and wait for reimbursement.
- The debit card works when you buy medical goods or services from a merchant with a special medical Merchant Category Code. The code tells the IRS that you used your debit card for an approved medical expense. Some places do not have a medical Merchant Category Code, but they have a special inventory control system that will still let the IRS know that you've used your card for an approved purchase. So your card will work as long as the place you are buying goods or services from has the medical Merchant Category Code or the special inventory control system.

Flexible Spending Accounts

Health Care Reimbursement Account (HCRA), continued

- If your merchant doesn't have either a medical Merchant Category Code or inventory control system, your purchase may not go through. If this happens, pay cash up-front and then file a claim for reimbursement with EBC.
- Keep in mind that if the amount you charge on your debit card is not a fixed copay amount like an office visit or prescription drug copay, you'll need to send your receipt to EBC to verify that it is an eligible expense. So, save those receipts! If you don't send in a receipt when EBC asks, your debit card will be de-activated.

If you have a cash register receipt that doesn't identify the drug, send other proof—you could send the receipt that shows the cost and the date you made the purchase, along with the box top that shows the price. Call EBC, our administrator, with questions at (248) 855-8040.

For a complete list of the expenses eligible for reimbursement, visit the IRS website at www.irs.gov/pub/ irs-pdf/p502.pdf.

Dependent Care Reimbursement Account (DCRA)

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

In 2025, the most you can put into the DCRA is $5,000. But if both you and your spouse work, the IRS limits your maximum contribution to a DCRA.

- If you file separate income tax returns, the annual contribution amount is limited to $2,500 each for you and your spouse.
- If you file a joint tax return and your spouse also contributes to a DCRA, your family's combined limit is $5,000.
- If your spouse is disabled or a full-time student, special limits apply.
- If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000.

With a DCRA, 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 DCRA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually the DCRA 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 DCRA, 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.

Flexible Spending Accounts

For Both HCRA and DCRA

All claims must be incurred by December 31, 2025 for the 2025 plan year. Claims incurred prior to your enrollment in the plan are not eligible for reimbursement. All 2025 expenses must be submitted to Employee Benefit Concepts, Inc. (EBC) by March 31, 2026. You should consider submitting your expenses as they occur. This will help avoid year end processing delays.

Debit Card (HCRA only)

Once EBC has your HCRA election in the system optional debit cards may be ordered online through the Summit Participant Portal at Groupresources.summitfor.me. Any additional cards that you may need for may be ordered by phone at 248-855-8040 or email flexclaims@groupresources.com. There is no fee for additional cards.

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

IRS regulations state money remaining in HCRA or DCRA accounts at the end of the year must 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 HCRA 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.*

Flexible Spending Accounts

The Summit Participant Portal provides online access that lets participants see their plan information and balances, enter claims, make payments, and make updates to personal and banking information.

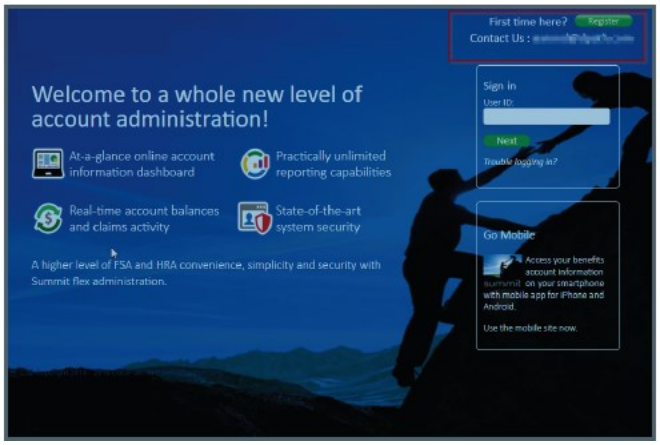
Go to Groupresources.summitfor.me

First Time Login

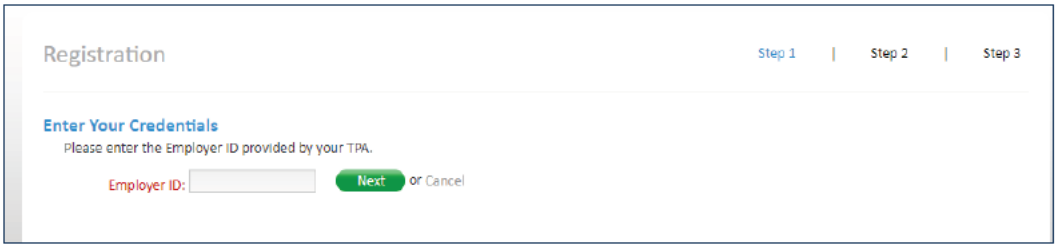
After you have been added to Summit with a valid email address, the system will send you a personalized link to use to register your online account. (Alternatively, you may receive a letter or email from EBC / Group Resources or employer that contains the Participant Portal link and the Employer ID you need to register your account.)

- TPA ID: 137
- Employer ID: EDS
- Participant ID: Last four of your SSN

If you did not receive a personal registration link but know your Employer ID, you can register your online account by clicking the **Register** button at the top right of the login screen.



If you have clicked the **Register** button, this is the next screen you'll see. Enter the Employer ID number and click **Next**.



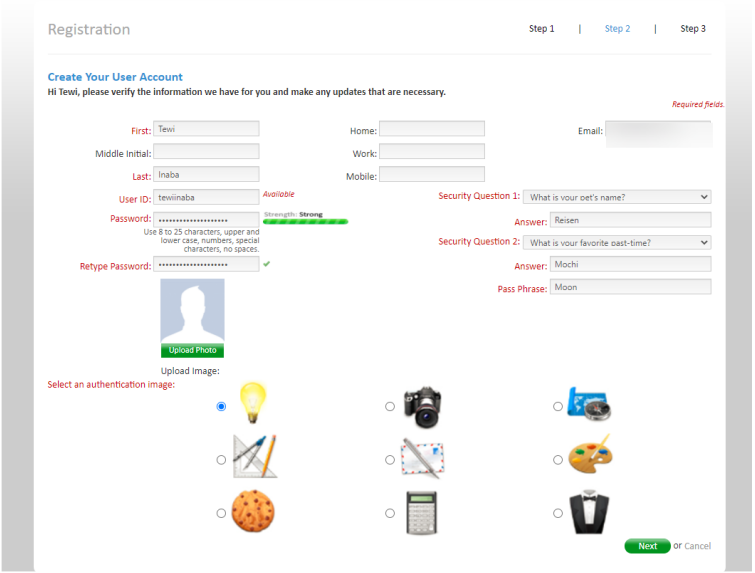
summit

This takes you to the Create Your User Account screen. Provide the requested information and click **Next**.

NOTE: If you were provided with a personalized link, this is the first screen you will see.

After you complete the Create Your User Account section, you are asked to Review Your Information to confirm accuracy. If there are changes, click the Edit button at the lower right and make them. Otherwise, click Finish.

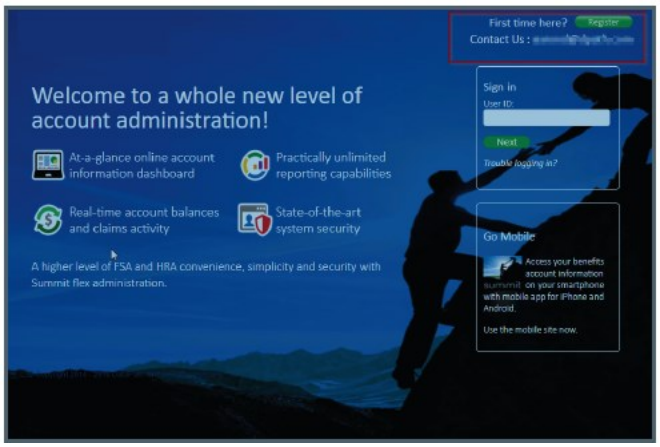
After clicking Finish, you will be taken to the Participant Portal home page to log in for the first time.



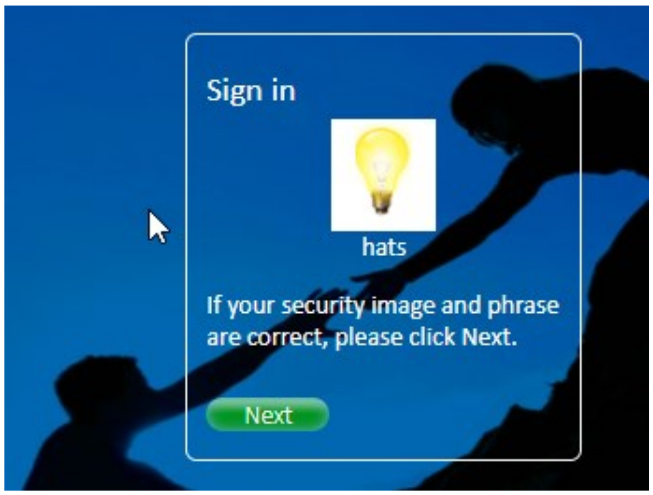
Flexible Spending Accounts

Logging In (Registered Participants)

Enter the login credentials you set up when registering your online account. After entering your user ID, click the Next button.



The Sign In box displays the security image and the image pass phrase that you selected when registering your online account. If these are correct, click **Next** to proceed with the login process.



Enter the password you set up when registering your online account, and click **Sign In**.

You have now logged in and will be taken to your Participant Portal home page, where you will be prompted to acknowledge any alerts or new items waiting for you there.

Employee Assistance Program

Eastpointe Community Schools is pleased to offer this no-cost benefit through our life insurer, Mutual of Omaha. 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.

When you or your family members have questions, concerns or emotional issues surrounding your personal or work life, you can contact the EAP for help. Mutual of Omaha's EAP offers access to master's-level consultants by telephone, along with resources and tools online. If additional resources are needed, your EAP professional can assist by locating affordable solutions in your area.

Services are available on a live basis 24 hours a day, 7 days a week, and your use of this service 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.

As an employee, or eligible dependent, of Eastpointe Community Schools your EAP benefits include:

- Information and referral services
  - Emotional well-being
  - Family and relationships
  - Legal and financial
  - Healthy lifestyles
  - Work and life transitions
- Service for employees and eligible dependents
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap
- Online Resources for:
  - Substance use
  - Dependent and Elder Care resources
- Legal library and online forms
- Financial assessment and online tools

Mutual of Omaha's Employee Assistance Program provides professional, confidential quality consultation, 24 hours a day.
Website: mutualofomaha.com/eap
Telephone: 1-800-316-2796

EAP—Additional Services

Eastpointe Community Schools is pleased to offer additional no-cost benefits through our life insurer, Mutual of Omaha.

Travel Assistance

Mutual of Omaha's travel assistance services are provided by AXA Assistance USA (AXA). Take comfort in knowing that Travel Assistance travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Travel assistance services include:

- Emergency Travel Support Services
- Medical Assistance
- Identity Theft
- Education and Prevention
- Recovery Information

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free:	Outside the U.S. call collect:
1-800-856-9947	(312) 935-3658

Pre-Trip Assistance—Minimize travel hassles by calling pre-departure for:

- information regarding passport, visa or other required documentation for foreign travel
- travel, health advisories and inoculation requirements for foreign countries
- domestic and international weather forecasts
- daily foreign currency exchange rates
- consulate and embassy locations

Identity Theft Assistance

Mutual of Omaha's identity theft assistance services are provided by AXA Assistance USA (AXA). AXA helps you and your dependents understand the risks of identity theft, learn how to prevent it, and most importantly, assist you if your information is compromised.

ID Theft Assistance is available as part of your overall Travel Assistance package offered by your employer. Services include:

- Awareness and Education
  - ⇒ promoting awareness and identity theft
  - ⇒ answering your questions about identity theft and how to recognize if you've become a victim
  - ⇒ educating you on how to avoid having your identity stolen
- Identify Theft Recovery Assistance

If your identity is compromised, the most important thing to do is respond quickly. AXA will provide you with educational resources regarding the steps to take to recover your identity from credit card and check fraud. AXA will also provide you with a contact list for financial institutions, credit bureaus and check companies.

Access ID Theft Assistance services by calling AXA Assistance toll-free at (800) 856-9947.

EAP—Additional Services (continued)

Eastpointe Community Schools is pleased to offer additional no-cost benefits through our life insurer, Mutual of Omaha.

Hearing Discount Program

Mutual of Omaha's Hearing Discount Program is provided by Amplifon. Program benefits include:

- Custom hearing solutions – Amplifon will find the solution that best fits your lifestyle and your budget from one of their 10 manufacturers
- Risk-free 60-day trial – 100 percent money-back guarantee on hearing aid purchase
- Hearing aid low price guarantee – if you find the same product at a lower price, bring Amplifon the local quote and they not only match it, they beat it by 5 percent
- Continuous Care – one year free follow-up, two years of free batteries and a three-year warranty

Accessing Benefits:

1. Call Amplifon at 1-888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

Will Prep

Mutual of Omaha's will preparation services are provided by Epoq. Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home. Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Voluntary Benefits

Critical Care

Eastpointe Community Schools provides an option to employees to enroll in supplemental insurance coverage. Critical care protection provides covered members a lump sum benefit upon diagnosis of a covered health event, with additional benefits paid such as hospital stays and continuing care. The cash benefits can help with expenses major medical may not cover.

Aflac delivers protection for all stages of the following covered events: heart attack, coronary artery bypass graft surgery, third -degree burns, major human organ transplant, end-stage renal failure, sudden cardiac arrest, stroke, coma, paralysis and persistent vegetative state.

Aflac is only offering Option 2, no new enrollments will be allowed in Options 1 and 3. If you are currently enrolled in Option 1 or 3 your coverage will remain with no changes. For a summary of those benefits please contact Aflac.

Benefit	Description (Option 2)
First-Occurrence Benefit	Named Insured/Spouse: $10,000; lifetime maximum $10,000 per covered person Dependent Children: $13,000; lifetime maximum $13,000 per covered person
Subsequent Specified Health Event Benefit	$5,000. No lifetime maximum. Subsequent occurrence limitations apply.
Coronary Angioplasty Benefit	$1,000 Payable only once per covered person, per lifetime.
Hospital Confinement Benefit	$300 per day. No lifetime maximum.
Continuing Care Benefit	$125 each day when a covered person is charged for any of the following treatments: • Rehabilitation Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy, Dietary Therapy/Consultation, Home Health Care, Dialysis, Hospice Care, Extended Care, Physician Visits and Nursing Home Care Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered specified health event or coronary angioplasty. No lifetime maximum.
Ambulance Benefit	$250 ground or $2,000 air. No lifetime maximum.
Transportation Benefit	$.50 per mile; limited to $1,500 per occurrence. No lifetime maximum.
Lodging Benefit	Up to $75 per day; limited to 15 days per occurrence. No lifetime maximum.
Hospital Intensive Care Unit Benefit	Days 1–7: $1,600 per day; Days 8-15: $2,600 per day; limited to 15 days per period of confinement. No lifetime maximum.
Step-Down Intensive Care Unit Benefit	$1,000 per day: Limited to 15 days per period of confinement; no lifetime maximum
Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement	An indemnity of $2 will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date.
Waiver of Premium Benefit	Premium waived, from month to month, during total inability (after 180 continuous days)
Continuation of Coverage Benefit	Waives all monthly premiums for up to 2 months, when all conditions for this benefit are met

Voluntary Benefits

Accident

Eastpointe Community Schools provides an option to employees to enroll in supplemental insurance coverage. Accident coverage protects covered members in the event of the unexpected. Accident protection provides cash benefits to use for any expenses from groceries to bills when an accident occurs such as a fall or sports injury.

Aflac is only offering Option 2, no new enrollments will be allowed in Options 1, 3 and 4. If you are currently enrolled in Option 1, 3 and 4 your coverage will remain with no changes. For a summary of those benefits please contact Aflac.

Benefit	Description (Option 2)
Accident Treatment Benefit	Payable once per 24-hour period and only once per covered accident, per covered person. Hospital emergency room with X-ray: $200, Hospital emergency room without X-ray: $170, Office or facility (other than a hospital emergency room) with X-ray: $150, Office or facility (other than a hospital emergency room) without X-ray: $120
Organized Sporting Activity	Additional 25% of the benefits payable, limited to $1,000 per policy, per calendar year
Initial Accident Hospitalization	$1,000 when admitted for a hospital confinement of at least 18 hours or $1,500 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
Accident Hospital Confinement	$200 per day, up to 365 days per covered accident, per covered person
Intensive Care Unit Confinement	Additional $400 per day for up to 15 days, per covered accident, per covered person
Ambulance	$150 ground ambulance transportation or $1,000 air ambulance transportation
Appliances	Benefits are payable for the medical appliances listed below: Back brace: $250, Body jacket: $250, Knee scooter: $250, Wheelchair: $250, Leg brace: $75, Crutches: $50, Walker: $50, Walking boot: $50 and Cane: $25 Payable once per covered accident, per covered person
Accident Follow-up Treatment	$25 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
Therapy Benefit	$25 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
Accident Specific-Sum Injuries	Pays benefits for the treatments listed below: Dislocations, Burns, Skin Grafts, Eye Injuries, Lacerations, Fractures, Concussion, Emergency Dental Work, COMA, Paralysis, Surgical Procedures, Miscellaneous Surgical procedures and Pain Management—Payments vary by for each condition
Major Diagnostic/Imaging Exams (MRI, CT Scan, etc.)	$150, per person, per calendar year
Prosthesis-New/Repair-Replacement	New: $500; Repair/Replacement: $500; per lifetime
Rehabilitation Facility	$100 per day
Home Modification	$2,000
Accidental-Death	Common-Carrier Accident / Other Accident / Hazardous Activity Accident Insured: $100,000 / $25,000 / $10,000 Spouse:: $100,000 / $25,000 / $10,000 Child: $15,000 / $10,000 / $5,000
Accidental-Dismemberment	$250-$25,000
Family Support	$20 per day, up to 30 days
Continuation of Coverage	Waives all monthly premiums for up to two months, if conditions are met
Waiver of Premium	Yes
Transportation & Family Lodging	Transportation: $400 per trip, up to three per year ; Family Lodging: $100 per night, up to 30 days

Voluntary Benefits

Cancer Care

Eastpointe Community Schools provides an option to employees to enroll in supplemental insurance coverage. Cancer care provides covered members financial benefits to help with the unexpected expenses associated upon initial diagnosis of a covered cancer with other benefits provided throughout cancer treatment.

Aflac is only offering Option 2, no new enrollments will be allowed for prior options. If you are currently enrolled in prior option your coverage will remain with no changes. For a summary of those benefits please contact Aflac.

Benefit	Description (Option 2)
Cancer Screening	$75 per year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
Prophylactic Surgery (Due to a positive genetic test result)	$250 per covered person, per lifetime
Initial Diagnosis Benefit	Named Insured or Spouse: $4,000 Dependent Child: $8,000 Payable once per covered person, per lifetime
Additional Opinion	$300 per covered person, per lifetime
Radiation Therapy, Chemotherapy, Immunotherapy or Experimental Chemotherapy	Self-Administered: $250 per calendar month Physician Administered: $1,200 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month
Hormonal Therapy	$25 once per calendar month
Topical Chemotherapy	$150 once per calendar month
Antinausea Benefit	$100 once per calendar month
Stem Cell and Bone Marrow Transplant	$7,000; lifetime maximum of $7,000 per covered person Donor Benefit: $100 for stem cell donation, or $750 for bone marrow donation Payable one time per covered person
Blood and Plasma	Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $175 per day, per covered person
Surgical/Anesthesia Benefit	$100-$3,400 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $4,250; no lifetime maximum on the number of operations
Skin Cancer Surgery Benefit	Laser or Cryosurgery: $35 Excision of lesion of skin without flap or graft: $170 Flap or graft without excision: $250 Excision of lesion of skin with flap or graft: $400 Maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations
Prophylactic Surgery (With correlating internal cancer diagnosis)	$250 per covered person, per lifetime
Hospitalization Confinement for 30 days or less	Named Insured or Spouse: $200; Dependent Child: $250
Hospitalization Confinement for Days 31+	Named Insured or Spouse: $400; Dependent Child: $500
Outpatient Hospital Surgical Room Charge Benefit	$200 per day, per covered person

Voluntary Benefits

Whole Life Insurance

Eastpointe Community Schools provides an option to employees to enroll in supplemental insurance coverage. Employees can purchase up to $500,000 of whole life insurance. Amounts up to $50,000 are guaranteed without answering eligibility or underwriting questions. Whole life insurance helps members and their families with financial resources that are needed to help with funeral expenses, bills and debt, education plans and future retirement.

Benefit	Description
Face Amount Choices	$20,000-$500,000 ($200,000 if over age 50).
Guaranteed-Issue	Available for the named insured only for up to $50,000 of coverage. Participation requirements must be met.
Builds Cash Value	Builds cash value that can potentially be borrowed later to help with retirement, college tuition or any other bills the policy owner may face.
Income Tax Protection for Increases in the Cash Value	Any increase in the cash value of a whole life policy is not subject to income tax while the cash remains in the policy.
Accelerated Death Payment (Named insured only)	Pays 50% of the policy's face amount when the named insured is diagnosed with a terminal condition.
Guaranteed Premiums	Premium will not change. Coverage will cost the same from month to month and year to year.
Payroll Deducted	Premium can be deducted from the named insured's paycheck.
Portable	Named insured can take the policy with them if they change jobs or retire.
Available Riders	
Spouse 10-Year Term Life	• Face amount: $10,000-$50,000. • Pays 50% of the policy's face amount up to a maximum of $50,000 for life insurance coverage on the named insured's spouse.
Child Term Life	• Face amount: $5,000-$15,000. • Pays 25% of the policy's face amount up to a maximum of $15,000 for life insurance coverage on each insured child up to age 25.
Waiver of Premium (Named insured only)	• Waives policy premiums if named insured becomes totally disabled under the terms of the policy.
Accidental-Death Benefit (Named insured only)	• Pays additional amount equal to the face amount if the named insured dies as the result of a covered accident and occurs within 180 days of the covered accident. • Additional 25% of the face amount will be paid if named insured dies in an automobile accident while wearing a seat belt and is not at fault.

Contact Information

Provider	Benefit	Contact Information
Blue Cross Blue Shield of Michigan (BCBSM)	Medical/Rx	877-790-2583 www.bcbsm.com
ADN Administrator	Dental	248-901-3705 888-236-1100 www.adndental.com
NVA	Vision	800-672-7723 www.e-nva.com
Mutual of Omaha	Life/AD&D	800-877-5176 www.mutualofomaha.com
Employee Benefits Concepts	Flexible Spending Accounts	248-855-8040 ext. 302 248-855-2454 FAX www.myflexonline.com or email claims to: flexclaims@groupresources.com
EAP—Mutual of Omaha	Employee Assistance Program	800-316-2796 mutualofomaha.com/eap
Travel Assistance	Mutual of Omaha AXA Assistance USA (AXA)	Within the U.S: 800-8569947 Outside the U.S.: 312-935-3658
Identity Theft	Mutual of Omaha AXA Assistance USA (AXA)	800-856-9947
Hearing Discount Program	Mutual of Omaha/ Amplifon Hearing Health Care	888-534-1747
Will Prep	Mutual of Omaha/ Epoq, Inc.	www.willprepservices.com
Aflac	Voluntary Benefits	800-992-3522 www.aflac.com

Legal Notices

Children's Health Insurance Reauthorization Act (CHIPRA)

Qualified group health plans in States that provide medical assistance through either Medicaid or a Children's Health Insurance Program (CHIP or SCHIP) must provide a notice informing employees of the potential opportunity for state Medicaid or CHIP health care assistance for group health plan coverage. The notice must be provided to employees when initially eligible and during the annual enrollment. [Note: Health FSAs and qualified High Deductible Health Plans (HSA-compatible) are not qualified health plans.]

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

Michelle's Law Notice

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under Eastpointe Community Schools Group Health Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under Eastpointe Community Schools Group Health Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under Eastpointe Community Schools Group Health Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact your Human Resources.

Legal Notices

Newborns' and Mothers' Health Protection Act Notice

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

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

Women's Health and Cancer Rights Act of 1998

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 states 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. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you would like more information on WHCRA benefits, contact Human Resources.

Protecting Your Privacy

Eastpointe Community Schools is committed to the privacy of your health information. The administrators of Eastpointe Community Schools medical 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 Human Resources.

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. Eastpointe Community Schools reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Legal Notices

HIPAA Notice of Privacy Practices Reminder

Eastpointe Community Schools is committed to the privacy of your health information. The administrators of the Eastpointe Community Schools Group 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 the Human Resources.

HIPAA Special Enrollment Rights

Eastpointe Community Schools Initial Notice of Your HIPAA Special Enrollment Rights Our records show that you are eligible to participate in the Eastpointe Community Schools Group 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 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 the Human Resources.

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/ flmedicaidtplrecover y.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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Legal Notices

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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)

Legal Notices

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Legal Notices

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

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Eastpointe 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. Eastpointe Community Schools has determined that the prescription drug coverage offered by the [Insert Name of 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, your current Eastpointe Community Schools coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Eastpointe 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 Eastpointe 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 Eastpointe Community Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit **www.medicare.gov**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1□800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	November 4, 2024
Name of Entity/Sender:	Eastpointe Community Schools
Contact—Position/Office:	Human Resources
Address:	24685 Kelly Road, Eastpointe, MI 48021
Phone Number:	586-533-3009

Glossary of Terms

MEDICAL

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

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

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

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

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

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

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

Eligible Dependents – A child (under the age of 26) who is your natural child, adopted, under your legal guardianship, placed with you for adoption, or a stepchild. Disabled children regardless of age if they are determined by a physician to be totally and permanently disabled by a physical or mental condition that began before age 19.

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

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

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

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

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

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

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

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

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

Routine and Preventive Visits – Office visits for Wellness and Routine Physical (services include Well Child Care, Immunization, Routine Gynecological Exam and Pap Smear, Mammogram, PSA Test and Related tests, [including colonoscopies after age 50]).

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

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

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

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

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

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

Glossary of Terms

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

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

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

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

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

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

PRESCRIPTION DRUGS

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

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

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

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

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

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

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

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

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

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

DENTAL

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

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

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

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

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

Glossary of Terms

FLEXIBLE SPENDING ACCOUNTS (FSA)

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

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

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

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

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

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

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

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

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

Notes

EASTPOINTE
COMMUNITY SCHOOLS

2025 Benefit Guide

Local 120
Head Cooks

This benefit summary prepared by

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