Birmingham
PUBLIC SCHOOLS

Birmingham Public Schools

2025

EMPLOYEE BENEFIT GUIDE

Open Enrollment for 2025:

October 28-November 8, 2024

Open Enrollment

Now is the time to review your benefit needs for the upcoming plan year. Any changes you make to your benefit elections and dependent coverage will be effective from January 1, 2025 through December 31, 2025. This includes:

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

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

Changes for 2025

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

What You Need To Do

- Review this 2025 Benefit Guide and Summary of Benefits and Coverage documents.
- Choose the benefits that are best for you and your family for January 1, 2025.
- Login to your MyMESSA at https://secure.messa.org
- Follow instructions to complete your open enrollment
- ALL EMPLOYEES ARE REQUIRED TO ENROLL THIS YEAR EVEN IF THERE ARE NO CHANGES

Reminder: Most Americans must have medical coverage to meet the individual mandate under the Affordable Care Act (ACA) or they must pay an IRS tax. Enroll in one of the medical plans offered by Birmingham Schools to ensure that you meet your individual mandate and avoid the IRS tax.

All election changes must be made by November 8, 2024

Dependent Eligibility

Eligibility criteria for adult children age 19 and older

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

Dependent adult child, age 19-26

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

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

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

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

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

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

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

Non-dependent adult child, age 19-26

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

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

Qualified Changes in Status

Changing your Pre-Tax Contribution Amount Mid-Year

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

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

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

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

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

Medicaid Expansion

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

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

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

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

Medical Plan Options

Medical Coverage

Birmingham Public Schools offers the following medical plan options:

- MESSA Choices 1000/2000 Plan with Saver Rx
- MESSA Choices 1000/2000 Plan with 5 Tier Rx
- MESSA ABC Plan 2 2000/4000 with ABC Rx
- MESSA ABC Plan 2 2000/4000 with 5 Tier Rx
- Medical Opt-Out

MESSA Choices Plan

- The MESSA Choices Plan is underwritten by Blue Cross Blue Shield. The plan is designed as a customized Preferred Provider Organization (PPO).
- 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. For a list of PPO providers, visit www.messa.org. Choose "Search for a Provider " under Members section.
- 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/ MESSA participating provider. That's because the participating provider must accept BCBSM/MESSA'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.

MESSA ABC Plans with HealthEquity Health Savings Account

- The Consumer Driven Health Plan (CDHP) works much like our other PPO Plans. A consumer driven health plan pairs a high-deductible, lower premium health plan with a tax-free Health Savings Account (HSA) that reimburses you for current and future medical expenses. All services, including prescriptions and office visits are subject to the annual deductible with the exception of certain preventive care services. Preventive care services are covered at 100% with no deductible when performed by an in-network provider.
- HealthEquity® is the administrator of the Health Savings Account (HSA) with the MESSA ABC Plan. An HSA is an interest bearing account that enables you to pay for current health care expenses with tax-free money (such as deductible and coinsurance) or to save for future health care expenses. It is designed to follow you into retirement. Therefore, money rolls over year after year and earns interest.

Medical Coverage (Cont'd)

MESSA ABC Plans with HealthEquity Health Savings Account

It's important to note that the annual deductible under the CDHP works differently than the PPO Plans. Under the CDHP two person or family coverage, benefits for an individual will be payable only when the FULL family CDHP deductible has been met. That means that services for an individual are not covered after they have satisfied the individual deductible as they are under the other PPO plans.

How the High Deductible Health Plan Works

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

2025 HSA Contribution Limits

- **Single: $4,300**
- **Family: $8,550**
- **Catch-Up (Age 55+): $1,000**

It is your responsibility to be sure that you do not contribute more than the IRS maximum limit (includes employee and third- party contributions).

Health Savings Account (HSA)

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

Health Savings Account

- Health Savings Accounts (HSA) are available to employees enrolled in the Consumer Driven Health Plan (CDHP). To be eligible to contribute to an HSA, you cannot be covered by another health plan. This includes a Flexible Spending Account, Medicare or any health plan that does not qualify as a "consumer driven health plan". You must not have received VA benefits for non-service related care, or non- preventive Indian Health Services at any time over the past three months. Lastly, you cannot be claimed as a tax dependent by anyone else.
- An HSA is an interest bearing account that gives you a way to pay for current health care expenses (such as deductible and coinsurance) or to save for future health care expenses. An HSA is owned by you and is portable from employer to employer. The balance rolls over from year to year and may be used for future health care expenses during active employment or retirement.
- You can use the money in your HSA to pay for medical expenses for yourself, your spouse and tax dependents even if they are not covered under the CDHP. With an HSA, you do not have to submit a claim with receipts. Instead, you simply request a reimbursement (just like a bank account) or use the debit card to pay for medical expenses.
- With an HSA, you can only be reimbursed up to the amount that you have in your account. If you request a reimbursement for more than your balance, you may be charged an overdraft fee.

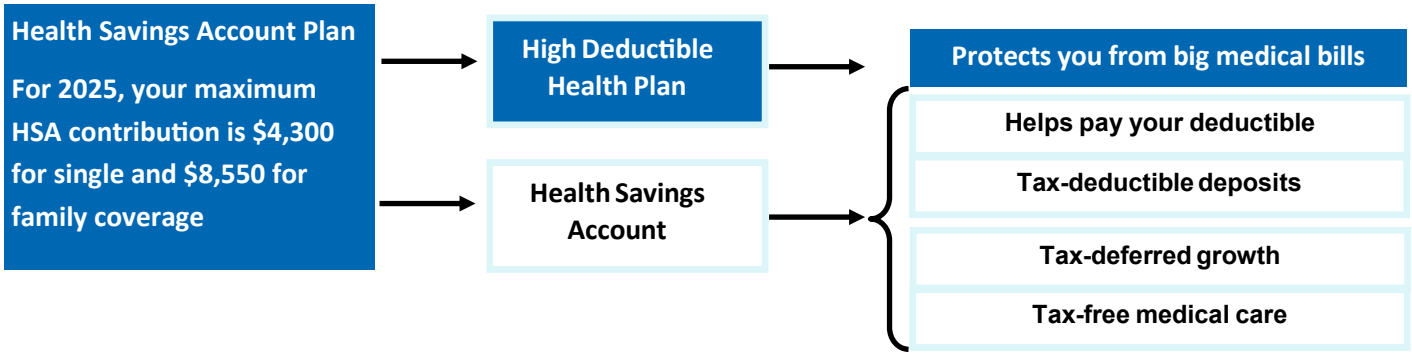
MESSA ABC Plans with HealthEquity Health Savings Account (Cont'd)

Medical Coverage (Cont'd)

Health Savings Account, continued

- The maximum annual contributions for 2025 are $4,300 for single coverage and $8,550 for family coverage.
- Individuals age 55 or older (and not enrolled in Medicare) may contribute an additional amount referred to as a catch-up contribution. The maximum annual catch-up contribution is $1,000.
- The money in your HSA can be withdrawn on a taxable basis for reasons other than a medical expense. The distribution is considered taxable income and is subject to a 20% penalty. Once you turn 65, or become disabled and/or enroll in Medicare, any distribution from your HSA for non-qualified medical expenses is considered taxable income but will not be subject to the 20% penalty.
- Once you turn 65, or become disabled and/or enroll in Medicare, you can continue to use funds from your HSA. However, after age 65, you will no longer be able to contribute money to it.
- It is your responsibility to report HSA activity on your tax return, including contributions to and distributions from your HSA during the year. You will need to maintain records of medical expenses.

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



Medical Coverage (Cont'd)

MESSA ABC Plans with HealthEquity Health Savings Account

Prorated HSA Contributions for Mid-Year Enrollments and Changes

If you do not have HSA-compatible health coverage for an entire calendar year, you must prorate your HSA contributions to avoid tax penalties. If you join the plan midyear, you may be able to take advantage of the last month rule and contribute the entire IRS maximum for the year.

Under the last month rule, if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year.

You are treated as having the same HDHP coverage for the entire year as you had on the first day of that last month. However, there is a testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last month rule, you must remain an eligible individual during the testing period.

For the last month rule, the testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month. For example, December 1, 2024, through December 31, 2025. If the employee does not satisfy the requirements of this "testing period," any contributions made the previous year (as well as any earnings made as the result of those contributions), in excess of 1/12 of the statutory maximum HSA contribution per month, must be included as income and will be subject to a 10% excise tax.

For more information:

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

Medical Opt-Out

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

Medical and Rx Plan Options

Choices 1000/2000 with Saver Rx

Plan features	In-network
Annual deductible The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	$1,000 individual/$2,000 family
Medical copayment A fixed amount you pay for a medical visit.	$20 Teladoc Health 24/7 care for minor illnesses, injuries and mental health, $20 Teladoc virtual primary care visit, $20 office visit for medical, mental health and/or substance use disorder treatment, $20 specialist visit, $25 urgent care, $50 emergency room, if not admitted
Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Subject to prescription copayments and coinsurance.	Saver Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services in a calendar year, including deductible, applicable coinsurance and copayments. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximums. **Prescription:** The most you have to pay for prescription copayments and coinsurance in a calendar year.	Medical: $2,000 individual/$4,000 family Prescription: $1,000 individual/$2,000 family
In-network preventive care – no cost to you	
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	**Prenatal and postnatal care** Prenatal and postnatal doctor visits.
In-network services subject to deductible and applicable copayment	
Emergency room (ER) Copayment waived if admitted or due to an accidental injury.	**Mental health and substance use disorder - outpatient care**
Office visit e.g. primary care physican, obstetrics and gynecology and pediatric visits.	**Specialist visit**

Medical and Rx Plan Options

Choices 1000/2000 with Saver Rx

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

Medical and Rx Plan Options

Choices 1000/2000 with 5 Tier Rx

Plan features	In-network
Annual deductible The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	$1,000 individual/$2,000 family
Medical copayment A fixed amount you pay for a medical visit.	$20 Teladoc Health 24/7 care for minor illnesses, injuries and mental health, $20 Teladoc virtual primary care visit, $20 office visit for medical, mental health and/or substance use disorder treatment, $20 specialist visit, $25 urgent care, $50 emergency room, if not admitted
Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Subject to prescription copayments and coinsurance.	5-Tier Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services in a calendar year, including deductible, applicable coinsurance and copayments. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximums. **Prescription:** The most you have to pay for prescription copayments and coinsurance in a calendar year.	Medical: $2,000 individual/$4,000 family Prescription: $2,000 individual/$4,000 family
In-network preventive care – no cost to you	
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	**Prenatal and postnatal care** Prenatal and postnatal doctor visits.
In-network services subject to deductible and applicable copayment	
Emergency room (ER) Copayment waived if admitted or due to an accidental injury.	**Mental health and substance use disorder - outpatient care**
Office visit e.g. primary care physican, obstetrics and gynecology and pediatric visits.	**Specialist visit**

Medical and Rx Plan Options

Choices 1000/2000 with 5 Tier Rx

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

Medical and Rx Plan Options

ABC 2 2000/4000 with ABC Rx

Plan features	In-network
Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	Single coverage: $2000 2-Person & Family coverage: $4000 When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.
Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See free preventive prescriptions below.	MESSA ABC Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	Single coverage: $3000 2-Person & Family coverage: $6000
In-network services covered at no cost to you	
Free preventive prescriptions MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.	No cost to you
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	
Prenatal and postnatal care Prenatal and postnatal doctor visits.	

Medical and Rx Plan Options

ABC 2 2000/4000 with ABC Rx

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

Medical and Rx Plan Options

ABC 2 2000/4000 with 5 Tier Rx

Plan features	In-network
Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	Single coverage: $2000 2-Person & Family coverage: $4000 When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.
Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See free preventive prescriptions below.	5-Tier Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	Single coverage: $4000 2-Person & Family coverage: $8000
In-network services covered at no cost to you	
Free preventive prescriptions MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.	No cost to you
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	
Prenatal and postnatal care Prenatal and postnatal doctor visits.	

Medical and Rx Plan Options

ABC 2 2000/4000 with 5 Tier Rx

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

Dental Coverage

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

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

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

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

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

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

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

Service	ADN 100/80 Plan	ADN 50/50 Plan Secretaries COB Only
Annual Deductible Type I, II and III Services	None	None
Annual Benefit Maximum Type I, II and III Services	$1,000 per person	$1,000 per person
Type I – Preventive/Diagnostic Diagnostic Services, Preventive Services, Radiographs	100% coverage	50% coverage
Type II—Basic Oral Surgery, Simple Fillings, Periodontics, Endodontics, Relines and Repairs of Bridges & Dentures	80% coverage	50% coverage
Type III—Major Restorative Prosthodontics; Major Restorative Services	80% coverage	50% coverage
Type IV—Orthodontic Services	80% coverage	80% coverage
Lifetime Maximum—Orthodontics	$1,000	$1,000

Vision Coverage

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

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

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

SCHEDULE OF BENEFITS: FULLY INSURED - ENHANCED (EFFECTIVE 01/01/2025)

Copayments (in-network only)			
Examination Copay		$5	
Lenses Only Copay		$7.50	
Frames		$0	
Contact Lenses		$0	
Medically Necessary Contacts Copay		$7.50	
Benefits	**Frequency**	**In-Network**	**Out-of-Network**
Eye Examination			
Routine Examination	Once every 12 months	Covered 100%	Up to $45
Lenses (Standard Glass or Plastic)			
Single Vision	Once every 12 months	Covered 100%	Up to $45
Bifocal	Once every 12 months	Covered 100%	Up to $65
Trifocal	Once every 12 months	Covered 100%	Up to $85
Lenticular	Once every 12 months	Covered 100%	Up to $100
Lens Options			
Prisms	Once every 12 months	Covered 100%	N/A
Frames			
Retail Frame Allowance[1]	Once every 12 months	Covered up to $130	Up to $70
20% Discount on Frame Balance[2]		Yes	N/A
Contact Lenses		In lieu of eyeglasses	
Elective[3,4]	Once every 12 months	Covered up to $125	Up to $85
15% discount on Conventional/10% discount on Disposable on remaining balance[5]		Yes	N/A
Medically Necessary[6]	Once every 12 months	Covered 100%	Up to $210

[1]Includes frames up to $52 every day low price-price point at Walmart/Sam's Club locations (if included in the network) and Costco.
[2]Discount does not apply at Walmart/Sam's Club locations, Costco, LensCrafters or for certain proprietary frame brands or where prohibited by law.
[3]Fitting & Follow-up Fees are deducted from the Contact Lens Allowance shown above unless otherwise specified.
[4]$88 every day low price-price point for contact lenses at Walmart/Sam's Club locations (if included in the network) and Costco.
[4]Discount does not apply at Walmart/Sam's Club locations, Cole corporate locations (if applicable), Costco, LensCrafters or Contact Fill or where prohibited by law. Prohibited by some manufacturers.
[5]Prior authorization required from NVA. Included fitting & follow up.
Note: if covered participants choose extra options, they are responsible for the additional cost of the options paid directly to the provider. Per the State of New Mexico's Department of Insurance regulations, any covered resident of the State of New Mexico must be provided a state-approved plan design which may differ from the selected plan design. Benefits apply to in-store services only at all retail locations, including but not limited to Walmart/Sam's Club, Costco and LensCrafters.

Basic Life and Accidental Death & Dismember-ment

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

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

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

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

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

Reminder:

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

A Note About Imputed Income:

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

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

Optional Short Term Disability Hourly Employees Only

Disability Coverage

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

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

A pre-existing condition is defined as an injury or sickness or related medical condition for which medical advice, care or treatment (including prescription drugs) was received during the three-month period ending on the effective date of coverage. In the event you have a pre- existing condition, no benefits are payable for disability for that condition. This pre-existing provision expires on the earliest of: 1) three consecutive months ending on or after the effective date of your insurance if during this time you do not incur any expenses or receive any medical treatment or services in connection with the condition;

2) six consecutive months if during this time you have been continuously insured and there has been no loss of time from active employment due to the condition; 3) twelve consecutive months if during this time you have been continuously insured.

Earnings are defined as base earnings not including overtime pay, bonuses, part-time employment, etc.

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the MESSA STD booklet for these details and other important provisions.

Optional Short Term Disability Disability

Disability Coverage

SHORT TERM DISABILITY PREMIUM COST 2025 Monthly Deduction Amount			
Annual Salary	**Weekly Benefit Amount**	**Deduction Amount 8th Day Waiting Period**	**Deduction Amount 29th Day Waiting Period**
$1,300.00	$20.00	$2.00	$1.40
$2,600.00	$40.00	$4.00	$2.80
$3,900.00	$60.00	$6.00	$4.20
$5,200.00	$80.00	$8.00	$5.60
$6,500.00	$100.00	$10.00	$7.00
$8,000.00	$120.00	$12.00	$8.40
$9,500.00	$140.00	$14.00	$9.80
$11,000.00	$160.00	$16.00	$11.20
$12,500.00	$180.00	$18.00	$12.60
$14,000.00	$200.00	$20.00	$14.00
$15,500.00	$220.00	$22.00	$15.40
$17,000.00	$240.00	$24.00	$16.80
$18,500.00	$260.00	$26.00	$18.20
$20,000.00	$280.00	$28.00	$19.60
$21,500.00	$300.00	$30.00	$21.00
$23,000.00	$320.00	$32.00	$22.40
$24,500.00	$340.00	$34.00	$23.80
$26,000.00	$360.00	$36.00	$25.20
$27,500.00	$380.00	$38.00	$26.60
$29,000.00	$400.00	$40.00	$28.00
$30,500.00	$420.00	$42.00	$29.40
$32,000.00	$440.00	$44.00	$30.80
$33,500.00	$460.00	$46.00	$32.20
$35,000.00	$480.00	$48.00	$33.60
$36,500.00	$500.00	$50.00	$35.00
$38,000.00	$520.00	$52.00	$36.40
$39,500.00	$540.00	$54.00	$37.80
$41,000.00	$560.00	$56.00	$39.20
$42,500.00	$580.00	$58.00	$40.60
$44,000.00	$600.00	$60.00	$42.00
$45,500.00	$620.00	$62.00	$43.40
$47,000.00	$640.00	$64.00	$44.80
$48,500.00	$660.00	$66.00	$46.20
$50,000.00	$680.00	$68.00	$47.60
$51,500.00	$700.00	$70.00	$49.00

Long Term Disability

Disability Coverage

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

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

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

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

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

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

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate / benefit booklet for details on these and other important provisions.

BEA and MESPA LTD benefits provided by MESSA.

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

Flexible Spending Accounts

Flexible Spending Accounts

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

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

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

These accounts help you save money.

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

You are eligible to participate in the Dependent Care Flexible Spending Account.

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

Flexible Spending Account (Cont'd)

HCFSA

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

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

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

Flexible Spending Accounts
2025 Maximum Annual Contribution

- **Health Care**: $3,300
- **Dependent Care**: $5,000, or $2,500

if married and filing separate tax returns

DCFSA

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

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

You can contribute up to $5,000 into your DCFSA, minimum contribution of $100. But if both you and your spouse work, the IRS limits your maximum contribution to a DCFSA.

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

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

HCFSA and DCFSA

Flexible Spending Account (Cont'd)

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

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

Eligible dependent care expenses can either be reimbursed through the DCFSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually the DCFSA will save more money than the tax credit. But to find out what is best for you and your family, talk to your tax advisor or take a look at IRS publication 503 at **http://www.irs.gov/publications/p503/index.html.**

If you contribute to a Dependent Care Flexible Spending Account, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

For Both HCFSA and DCFSA

All claims must be incurred by December 31, 2025 for the 2025 plan year. Claims incurred prior to your enrollment in the plan are not eligible for reimbursement. All 2024 expenses must be submitted to Health Equity by March 31, 2025. You should consider submitting your expenses as they occur. This will help avoid year end processing delays.

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

Any money left in a HCFSA or DCFSA account at the end of the year has to be forfeited. People call this the "use it or lose it" rule. This sounds scary, but don't let it keep you from enrolling in these accounts.

You can avoid losing money with some planning.

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

Dependent care expenses can be budgeted ahead of time.

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

Travel Assistance

UNUM Worldwide Emergency Travel Assistance Services

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

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

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

Contact Information

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

Required Notices

Required Notices

HIPAA Notice of Special Enrollment Rights

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

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

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

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

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

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

Newborns' and Mothers' Health Protection Act Notice

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

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

Required Notices (Cont'd)

Women's Health and Cancer Rights Act of 1998

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

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

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

Michelle's Law

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

Protecting Your Privacy

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

Disclosure about the Benefit Enrollment Communications

The benefit enrollment communications (the Benefit Guide, etc.) contains a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Birmingham Public Schools reserves the right to amend, modify or terminate any plan at any time and in any manner.

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

Required Notices (Cont'd)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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, 2023. Contact your State for more information on eligibility –

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

Required Notices (Cont'd)

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

Required Notices (Cont'd)

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)

Required Notices (Cont'd)

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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Required Notices (Cont'd)

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

IMPORTANT NOTE:

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Birmingham Public Schools and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Birmingham Public Schools has determined that the prescription drug coverage offered by the Birmingham Public Schools Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

1. You should also know that if you drop or lose your current coverage with Birmingham Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later

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

Required Notices (Cont'd)

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Birmingham Public Schools changes. You also may request a copy of this notice at any time.

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

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

- **Visit www.medicare.gov.**
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember:

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

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

Birmingham
PUBLIC SCHOOLS

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting