2020 New Hire Guide
All Benefit Eligible Employees
New Hire Enrollment Process

Congratulations on your new job with Lapeer Community Schools! Please review this guide carefully. All elections you make will be effective through December 31, 2020 unless you experience a qualified special enrollment event. Elections to the Flexible Spending Account (FSA) will be also be effective through December 31, 2020. Please reference the PlanSource Enrollment Packet for additional details and the enrollment form.

What do I need to do?

1. Read this booklet carefully. Please refer to page 7 & 8 for employee contributions.
2. Review the benefit information posted on LCS’s website and MESSA’s website.
3. Complete an LCS Election/Change of Status Form.
4. Complete a separate carrier enrollment form for PlanSource if you are participating in the FSA. The FSA maximum contribution is $2,750.
5. Consider enrolling in the Flexible Spending Account (FSA) - Review the PlanSource Enrollment packet to determine how much to contribute to your FSA. Only employees that are not participating in the MESSA ABC Plan/Health Savings Account (HSA) are eligible to participate in the Medical FSA. All employees, including those participating in the HSA are still able to participate in the Dependent Care Account.
6. Consider contributing to the Health Savings Account (HSA) if electing a MESSA ABC Plan. LCS Election/Change of Status Form is required.
7. If you are waiving coverage and receiving cash in lieu you must provide us with proof of other coverage each year.
8. Please return your forms to Human Resources. If you have questions about the forms please contact Krista Trevithick.

In addition to the information provided in this guide, please review the resources available on LCS’s website as well as MESSA’s website.
Medical and HSA Overview

Medical

LCS will offer two MESSA Choices options and two MESSA ABC options as follows:

<table>
<thead>
<tr>
<th>All Eligible Employees</th>
<th>MESSA Choices $500/$1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 OV/$25 UC/$50 ER/3 Tier &amp; Mandatory Mail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Eligible Employees</th>
<th>MESSA Choices $1,000/$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 OV/$25 UC/$50 ER/3 Tier &amp; Mandatory Mail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Eligible Employees</th>
<th>MESSA ABC Plan 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,400/$2,800, 3 Tier &amp; Mandatory Mail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Eligible Employees</th>
<th>MESSA ABC Plan 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,000/$4,000, 3 Tier &amp; Mandatory Mail</td>
</tr>
</tbody>
</table>

Please reference the MESSA benefit summaries on the District’s website. In addition, Summary of Benefits and Coverage (SBC) are also available on the District’s website. Please contact Human Resources if you would like a printed copy. Additional resources are also available on MESSA’s website (www.messa.org).

Health Savings Accounts (HSA)

In this guide, we have included information about Health Savings Accounts (HSA), which is available to ABC Plan participants. The next few pages provide an overview of the important requirements as well as some commonly asked questions. We encourage you to contact your tax adviser with specific HSA questions as the impact of these accounts changes based on circumstances.

There are several advantages to enrolling in a MESSA ABC Plan with an HSA.

- Contributions made to the HSA are pre-tax so your money goes further.
- Money in the HSA can also be used for dental and vision; the HSA allows you to pay for these services with pre-tax dollars. Any money spent on dental or vision does NOT count toward meeting your medical deductible.
- Your HSA can be used as a tax sheltered investment.
- The prescription drug plan offered with the ABC Plan provides free maintenance drugs such as medicines for high blood pressure and cholesterol.
- After you meet your deductible, medical services are covered at 100%. The only copays are for some prescription medications.
HSA Overview

What is an HSA?

A Health Savings Account (HSA) is a cross between a flexible spending account (FSA), an IRA, and a 401(k)/403(b). Only those who enroll in one of the MESSA ABC Plans have the option to participate in the HSA, if eligible. You can access your HSA to pay for eligible expenses. In addition, your account has the ability to grow, year-to-year, tax deferred. The HSA account is your property and responsibility. Like a 401(k)/403(b), it is your money and stays with you.

Eligibility

To be eligible, you must:
(a) Be covered by one of the MESSA ABC High Deductible Health Plans;
(b) Not be claimed as another person’s tax dependent;
(c) Not be covered by Medicare; and
(d) Not have any health coverage other than coverage under a High Deductible Health Plan. Other coverage that will disqualify you from being eligible for the HSA Contribution Feature includes, but not limited to, coverage under your spouse’s health plan if his/her plan is not considered a HDHP plan under IRS guidelines. Coverage under your spouse’s medical expense reimbursement plan or flexible spending account, and coverage under a health reimbursement arrangement, including your spouse’s health reimbursement arrangement.

Consideration

An HSA is an employee’s property and HSA account holders are responsible for ensuring they meet the eligibility requirements for the pre-tax benefit as well as ensuring the funds are used to pay for qualified medical expenses. The HSA is separate from the medical high deductible plan and is a bank account used to help pay for those expenses not covered by the plan with pre-tax dollars.

Using Your HSA

Money in your HSA can be used to pay for a variety of healthcare-related expenses for you and your IRS eligible dependents (any out of pocket medical, dental and vision coverage after the insurance plan pays or processes the claim) ranging from routine exams to prescription drugs. A full listing of eligible expenses can be found at: http://www.irs.gov/pub/irs-pdf/p969.pdf. To pay for expenses, you simply present your HSA debit card to your provider, and money will be deducted directly from your HSA.

Please note that you are not required to submit receipts for the purchases that you make. It is your responsibility to keep the supporting records to show the Internal Revenue Service whether you used the funds to pay qualified medical expenses.

HSA Employee Funding

You will have the option to fund your account with pre-tax dollars. The Statutory Maximum HSA Contribution for the 2020 calendar year is $3,550 for a single and $7,100 for a family. If you are age 55 or older, you can make an additional catch-up contribution amount of $1,000 in 2020. The HSA cannot receive contributions after you have enrolled in Medicare. You have the ability to adjust your HSA pre-tax election monthly.
Your HSA money is tax-free as long as it is used to pay for qualified medical, dental and vision expenses. If you use the money for any other reason, you will be required to pay income tax and a 20% tax penalty on that amount (you will not pay a penalty if you are disabled or age 65 or older).

The total contributions made by you and/or made on your behalf (i.e., contributions by your Employer) into HSAs owned by you are subject to a maximum contribution limit.

If you are eligible for contributions for only a portion of the year, your maximum contribution (including catch-up contributions) is determined in accordance with the following “rules”:

(a) Not Eligible on December 1st. If you cease to be eligible for contributions prior to December 1st of a particular year, the contribution limit for that year will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible.

For Example, if you have single coverage under a qualifying High Deductible Health Plan, you are not eligible for catch up contributions, but are eligible only during January through June (i.e., six months of the year), your maximum contribution would be limited.

(b) Eligible on December 1st. If you become eligible for HSA contributions during a particular year and you are eligible as of December 1st of that year, your maximum contribution for that year is the full indexed amount.

However, if you become ineligible for HSA contributions during the twelve (12) month period beginning with December of that year, you will not be entitled to the full maximum contribution. Instead, your maximum contribution will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible during that year. The excess contributions will be included in your gross income and an additional tax will be imposed on those contributions.

Rollover contributions may also be made to an HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above, however, exclusions do apply.

What happens if my contributions exceed the contribution limit?

1. If the contributions to your HSA exceed the applicable maximum contribution limit for a year, generally the excess contributions will be included in your income and an excise tax will be imposed upon them.
2. You can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return. This distribution must be included as a taxable income when you file your taxes.
What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions and the consequences of taking distributions is available from the trustee/custodian of your HSA.

When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in the Plan ceases or the date you no longer satisfy the eligibility requirements of the plan. You need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Plan.

NOTE: This HSA Contribution Feature is not a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature. However, COBRA, FMLA, and USERRA may apply to the Qualifying High Deductible Health Plan.

Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in you HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from IRS.
# Employee Contributions

## 100% Board Paid Allocation

**Period:** 1/1/2020 - 12/31/2020

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly HARD CAP MAX</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$629.95</td>
<td>$568.24</td>
<td>$61.71</td>
<td>$30.86</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,415.53</td>
<td>$1,188.36</td>
<td>$227.17</td>
<td>$113.58</td>
</tr>
<tr>
<td>Family</td>
<td>$1,761.18</td>
<td>$1,549.75</td>
<td>$211.43</td>
<td>$105.72</td>
</tr>
</tbody>
</table>

**MESSA Choices $500/$1000**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly HARD CAP MAX</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$592.07</td>
<td>$568.24</td>
<td>$23.83</td>
<td>$11.92</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,330.28</td>
<td>$1,188.36</td>
<td>$141.92</td>
<td>$70.96</td>
</tr>
<tr>
<td>Family</td>
<td>$1,655.10</td>
<td>$1,549.75</td>
<td>$105.35</td>
<td>$52.68</td>
</tr>
</tbody>
</table>

**MESSA ABC Plan 1**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly HARD CAP MAX</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$562.35</td>
<td>$568.24</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,263.42</td>
<td>$1,188.36</td>
<td>$75.06</td>
<td>$37.53</td>
</tr>
<tr>
<td>Family</td>
<td>$1,571.89</td>
<td>$1,549.75</td>
<td>$22.14</td>
<td>$11.07</td>
</tr>
</tbody>
</table>

**MESSA ABC Plan 2**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly HARD CAP MAX</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$525.81</td>
<td>$568.24</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,181.20</td>
<td>$1,188.36</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Family</td>
<td>$1,469.57</td>
<td>$1,549.75</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

## 50% Board Paid Allocation

**Period:** 1/1/2020 - 12/31/2020

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly Max 50% of HARD CAP</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$629.95</td>
<td>$284.12</td>
<td>$345.83</td>
<td>$172.92</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,415.53</td>
<td>$594.18</td>
<td>$821.35</td>
<td>$410.67</td>
</tr>
<tr>
<td>Family</td>
<td>$1,761.18</td>
<td>$774.87</td>
<td>$986.31</td>
<td>$493.15</td>
</tr>
</tbody>
</table>

**MESSA Choices $500/$1000**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly Max 50% of HARD CAP</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$592.07</td>
<td>$284.12</td>
<td>$307.95</td>
<td>$153.98</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,330.28</td>
<td>$594.18</td>
<td>$736.10</td>
<td>$368.05</td>
</tr>
<tr>
<td>Family</td>
<td>$1,655.10</td>
<td>$774.87</td>
<td>$880.23</td>
<td>$440.11</td>
</tr>
</tbody>
</table>

**MESSA ABC Plan 1**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly Max 50% of HARD CAP</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$562.35</td>
<td>$284.12</td>
<td>$278.23</td>
<td>$139.12</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,263.42</td>
<td>$594.18</td>
<td>$669.24</td>
<td>$334.62</td>
</tr>
<tr>
<td>Family</td>
<td>$1,571.89</td>
<td>$774.87</td>
<td>$797.02</td>
<td>$398.51</td>
</tr>
</tbody>
</table>

**MESSA ABC Plan 2**

<table>
<thead>
<tr>
<th>Rate Tier</th>
<th>MESSA Renewal Rates 1/1/20 - 12/31/20</th>
<th>2020 Monthly Max 50% of HARD CAP</th>
<th>&quot;HARD CAP&quot; Renewal Monthly Contributions</th>
<th>&quot;HARD CAP&quot; 2020 24 Pay Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$525.81</td>
<td>$284.12</td>
<td>$241.69</td>
<td>$120.85</td>
</tr>
<tr>
<td>Two Person</td>
<td>$1,181.20</td>
<td>$594.18</td>
<td>$587.02</td>
<td>$293.51</td>
</tr>
<tr>
<td>Family</td>
<td>$1,469.57</td>
<td>$774.87</td>
<td>$694.70</td>
<td>$347.35</td>
</tr>
</tbody>
</table>
Waiving Coverage

If you waive Medical coverage because you have coverage elsewhere, you may be eligible for Cash in Lieu payments based on the terms of your collective bargaining agreement. Proof of other coverage is required every year.

If you waive enrollment in the plan at this time, you may not be able to obtain coverage until the next open enrollment period in 2020, unless you experience a qualifying event.

Please contact Krista Trevithick if you would like a printed copy of any of the materials referenced throughout this document.
Introduction

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren’t required to pay] for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
Continuation Coverage Rights Under COBRA (continued)

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Melissa Montgomery.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage,
Continuation Coverage Rights Under COBRA (continued)

the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Lapeer Community Schools, Attention Krista Trevithick, 250 2nd Street, Lapeer, MI 48446 Phone: (810) 538-1610.
Your Rights Under Federal Law

Special Enrollment Events / Changes In Family Status

If you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents provided that you request enrollment within 30 days after the event. These events are referred to as changes in “family status.” In addition, if you were to lose coverage through another source, if the event qualified as a “family status” change, you must request enrollment within 30 days after the coverage ends. When you become enrolled as the result of a Special Enrollment Event, coverage will be made effective on the date of the event.

Women’s Health and Cancer Rights Act of 1998

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- 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 for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes).

The group health plan must determine the coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborn and Mother’s Health Protection Act

This 1998 Federal law states: "Group plans and health insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth".

The law provides that neither you nor your newborn baby may be sent home less than 48 hours following a natural childbirth. If you have a Caesarean section, you may remain at the hospital for 96 hours. A longer stay is based on medical necessity, which is determined by your physician.

However, the law does not prohibit either you or your newborn from going home in less than 48 hours following natural childbirth, or 96 hours following a Caesarean section, provided that you or your physician agrees that it is safe to do so.
## Your Benefit Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>MESSA—Choices or ABC</td>
<td><a href="http://www.messa.org">www.messa.org</a></td>
<td>800.292.4910</td>
</tr>
<tr>
<td></td>
<td>Mail Order Prescription—Express</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scripts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>ADN Administrators</td>
<td><a href="http://www.adndental.com">www.adndental.com</a></td>
<td>888.ADN.1100</td>
</tr>
<tr>
<td>Vision</td>
<td>National Vision Administrators</td>
<td><a href="http://www.e-nva.com">www.e-nva.com</a></td>
<td>800.672.7723</td>
</tr>
<tr>
<td></td>
<td>(NVA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>PlanSource</td>
<td><a href="http://www.plansource.com">www.plansource.com</a></td>
<td>888.266.1732</td>
</tr>
</tbody>
</table>
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lapeer 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. Lapeer Community Schools has determined that the prescription drug coverage offered by the Lapeer Community 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.

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 Lapeer Community Schools’ coverage may not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Lapeer Community Schools’ coverage, be aware that you and your dependents may not be able to get this coverage back unless you experience a family status change or until next open enrollment period.

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 Lapeer 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 Medicare prescription drug coverage:

1. Visit www.medicare.gov
2. 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

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

Date: October 24, 2019
Name of Entity/Sender: Lapeer Community Schools
Contact--Position/Office: Krista Trevithick
Address: 250 Second Street
          Lapeer, MI 48446
Phone Number: 810.538.1610

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).
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the healthcare law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes, if you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact _____________________________.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name
   Lapeer Community Schools

4. Employer Identification Number (EIN)
   38-6002216

5. Employer address
   250 Second Street

6. Employer phone number
   810-538-1611

7. City
   Lapeer

8. State
   MI

9. ZIP code
   48146

10. Who can we contact about employee health coverage at this job?
    Mark Rajter

11. Phone number (if different from above)

12. Email address
    mrajet@lapeerschools.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  - All employees. Eligible employees are:
    Full-time employees working 30 hours or more

  - Some employees. Eligible employees are:

- With respect to dependents:

  - We do offer coverage. Eligible dependents are:
    Dependents to age 26

  - We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
Full Privacy Notice

This notice describes how the Plan may use and disclose your protected health information (PHI) and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact the Privacy Officer Kim Seifferly at (810) 538-1602.

Our Policy Regarding PHI. We understand that health information about you obtained in connection with the Plan is personal, and we are committed to protecting your health information. For Plan administration purposes, we may maintain information related to your coverage under the Plan that identifies you and relates to your physical or mental health, related health care services, and payment for health care. This information is called Protected Health Information, or PHI.

This Notice tells you the ways in which we may use and disclose your PHI. It also describes our obligations and your rights regarding the use and disclosure of PHI.

We are required by law to:

- Keep PHI obtained and created by the Plan private;
- Provide you with certain rights with respect to your PHI;
- Give you this Notice of our legal duties and privacy practices with respect to PHI;
- Follow the terms of the Notice of Privacy Practices that is currently in effect; and
- Notify affected individuals if a breach occurs that may have compromised the privacy or security of PHI.

How We May Use and Disclose PHI. The following categories describe how we may use and disclose PHI without your written authorization. We may use and disclose PHI:

- **For treatment.** To facilitate health treatment or services by providers.
- **For payment.** To determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your PHI with a utilization review or precertification service provider. Likewise, we may share your PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.
- **For health care operations.** For operations necessary to run the Plan. For example, we may use PHI for underwriting, premium rating, and other activities relating to Plan coverage, to submit claims for stop-loss coverage; conduct or arrange for health review, legal services, audit services, and fraud and abuse detection; business planning and developing such as cost management; and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.
- **To communicate with business associates.** Some services are provided to the Plan through contracts with “business associate.” We may disclose PHI to our business associates so that they can perform a service for the Plan. To protect your PHI, we require business associates to agree in writing to appropriately safeguard your information.
- **Disclosure to health plan sponsor.** Information may be disclosed to your employer’s personnel solely for purposes of administering benefits under the Plan. However, those employees are permitted to use or disclose your information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.
- **Other.** For other reasons permitted under HIPAA, such as when required to do so by law, for workers’ compensation or similar programs, or in response to a court or administrative order.
Your Rights. You have the following rights with respect to your protected health information:

- **Right to Inspect and Copy.** You may inspect and copy certain PHI that may be used to make decisions about your Plan benefits. We may charge a fee for the copying, mailing, or other costs associated with your request. We may deny your request to inspect and copy in very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

- **Right to Amend.** You may amend incorrect or incomplete PHI if you provide a reason that supports your request. We may deny your request if it is not in writing, does not include a reason to support the request, or if the information is not part of the PHI kept by or for the Plan, was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not information that you would be permitted to inspect or copy, or is accurate and complete.

- **Right to an Accounting of Disclosures.** You may request a list (an “accounting”) of the times we have shared your protected health information with others. The accounting will not include disclosures for purposes of treatment, payment, or health care operations; disclosures made to you; disclosures made pursuant to your authorization; or disclosures made for certain governmental functions. You must state a time period that is not longer than six years prior to the request. You should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free, but we may charge you for the costs of providing additional lists.

- **Right to Request Restrictions.** You may request a restriction or limitation on the disclosure of your PHI for treatment, payment, or health care operations, or to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. In your request, you must tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example, disclosures to your spouse. We are not required to agree to your request. If we agree with your request, we will comply with the restriction until it is terminated by you or us. We will not agree to restrictions on uses or disclosures that are legally required, that are necessary to operate our business, or that are burdensome.

- **Right to Request Confidential Communications.** You may request that we communicate with you about your PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate requests that specify how or where you wish to be contacted and that include a reasonable statement that disclosure of the information in another manner will endanger you.

- **Right to a Paper Copy of This Notice.** You may ask for a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

**Complaints.** If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact Kim Seifferly, Executive Director for Human Resources, at 810-538-1602. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**Changes to this Notice.** We may revise this Notice and reserve the right to make the revised Notice effective for PHI we possess as of the date of the revision as well as any information we receive after the change. The new Notice will be available, upon request, on our intranet, and we will distribute a paper copy.
This guide summarize certain features of Lapeer Community Schools benefits plans. Full details of the plans can be found in the carrier booklets, the carrier booklets will govern. Lapeer Community Schools reserves the right to amend or terminate these benefits at any time. The information in this guide does not constitute a contract of employment. If you have any questions about the benefit plans described in this guide, please contact the benefits department.