OXFORD COMMUNITY SCHOOLS

WHERE THE GLOBE IS OUR CAMPUS

Oxford Community Schools
2023
EMPLOYEE BENEFIT GUIDE

2023 BENEFITS

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Oxford Community Schools is proud to offer a comprehensive benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical and dental), and Oxford Community Schools provides other benefits at no cost to you (life, accidental death & dismemberment, and long term disability).

BENEFITS OFFERED

- Medical
- Dental
- Vision
- Life AD&D Insurance
- Long Term Disability
- Health Savings Accounts (HSA)
- Health Reimbursement Account (HRA)
- Flexible Spending Account (FSA)
- EAP

ELIGIBILITY

You and your dependents are eligible for Oxford Community Schools benefits on the first of the month following date of hire.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or OCS eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, **you must contact HR within 30 days.**

This document is an outline of the coverage proposed by the carrier(s)), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

MEDICAL COVERAGE

MEDICAL - Blue Cross Blue Shield of Michigan and Blue Care Network

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. The following pages will outline your coverage with **Oxford Community Schools**

Medical Plans

- **BCN HMO 1400 with Health Savings Account**
- **BCN HMO 2800 with Health Savings Account**
- **BCN HMO 5000 with Health Reimbursement Account**
- **Simply Blue PPO 1400 with Health Savings Account**

2023 HSA Contribution Limits

- **Single: $3,850**
- **Family: $7,750**
- **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).

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.

What is?

HRA= Health Reimbursement Account - A benefit set up by your employer which pays for medical expenses not covered by your health plan, such as the deductible. *The fund is owned by your employer*. Your employer decides which expenses are covered by the HRA (i.e., deductible). The money in an HRA *cannot* be invested or rolled over to the next year.

HSA= Health Savings Account - Similar to a 401(k) retirement account, but it is for medical expenses. You can only have an HSA if you enroll in an HSA- compatible insurance plan (a high deductible health plan, or HDHP), but you are not required to open an HSA if you enroll in a qualified HDHP. *You own the account* . Money can be deposited from your paycheck before tax.

FSA= Flexible Spending Account - Set up by your employer, you get to decide which qualified medical expenses to pay for with your FSA. It works with most employer-sponsored health plans (medical, dental, vision). You can only deposit money into your FSA through payroll deduction. That money isn't taxed. Any money left in the account at the end of the year is forfeited - you *cannot* roll a remaining balance over to the next year.

MEDICAL PLAN OPTIONS

Oxford Community Schools offers the following medical plan options through Blue Cross Blue Shield of Michigan The information below and in the following pages provide a high-level overview. Please review plan documents for a more comprehensive summary of benefits.

Blue Care Network of Michigan	BCN HSA HMO 1400	BCN HSA HMO 2800	BCN HRA HMO 5000	SIMPLY BLUE 1400 HSA PPO
What Are YOUR Out-of-Pocket Expenses with the HSA/HRA Funding?				
	For 2-P/F contract, entire family deductible must be met	$2800/member. Two or more members may meet 2-P/F deductible	$500member. Two or more membersmay meet 2-P/F deductible.	For 2-P/F contract, entire family deductible must be met
What You Pay for Deductible	$1,400 single $2,800 family	$2,800 single $6,000 family	$500 single $1,000 family	$1,400 single $2,800 family
	HSA	**HSA**	**HRA**	**HSA**
What Oxford Pays for Deductible	$0 $0	$0 $0	$4,500 $9,000	$0 $0
What You Pay for TRUE-Out-of-Pocket (TROOP)	$2,350 single $4,700 family	$6,900 single $13,800 family	$1,850 single $3,700 family	$2,250 single $4,500 family
What are the Actual Plan Costs without Oxford HRA/HSA funding?	In-Network	In-Network	In-Network	In-Network
Annual Deductible	$1,400 single $2,800 family	$2,800 single $6,000 family	$5,000 single $10,000 family	$1,400 single $2,800 family
Coinsurance	0%	0%	20%	20%
Medical Annual Out-of-Pocket Maximum (includes deductible)	$2,350 single $4,700 family	$6,900 single $13,800 family	$6,350 single $12,700 family	$2,250 single $4,500 family
DOCTOR'S OFFICE				
Primary Care Office Visit	100% after in-network deductible	100% after in-network deductible	$20 copay	100% after in-network deductible
Specialist Office Visit	100% after in-network deductible	100% after in-network deductible	$40 copay	100% after in-network deductible
Urgent Care Visit	100% after in-network deductible	100% after in-network deductible	$50 copay	100% after in-network deductible
Online Visit	100% after in-network deductible	100% after in-network deductible	$20 copay	100% after in-network deductible
Preventive care ***see plan documents for clarification and further details**	*No cost to you. Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications.	*No cost to you. Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications	*No cost to you. Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications	*No cost to you. Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications

MEDICAL PLAN OPTIONS

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	BCN HSA HMO 1400	BCN HSA HMO 2800	BCN HRA HMO 5000	SIMPLY BLUE 1400 HSA PPO
PRESCRIPTION DRUGS				
Prescription Coverage (30 day)	Copays applies after deductible	Copays applies after deductible	Copays applies after deductible	Copays applies after deductible
Generic	$4 (1a) or $15 (1b) Copay	$4 (1a) or $15 (1b) Copay	$4 (1a) or $15 (1b) Copay	$4 (1a) or $15 (1b) Copay
Preferred Brand	$40 Copay	$40 Copay	$40 Copay	$40 Copay
Non preferred Brand	$80 Copay	$80 Copay	$80 Copay	$80 Copay
Specialty Drugs	20% Copay	20% Copay	20% Copay	20% Copay
Prescription Coverage (90 day)	Copays applies after deductible	Copays applies after deductible	Copays applies after deductible	Copays applies after deductible
Generic	$12 or $45 Less $10	$12 or $45 Less $10	$12 or $45 Less $10	$12 or $45 Less $10
Preferred Brand	$120 Less $10	$120 Less $10	$120 Less $10	$120 Less $10
Non preferred Brand	$240 less $10	$240 less $10	$240 less $10	$240 less $10
Specialty Drugs	20% Copay	20% Copay	20% Copay	20% Copay

You've made the decision to enroll in the Blue Care Network $1,400 HSA plan, now what?

How do I find providers?

To locate a provider, you can visit www.BCBSM.com. Click on the **Find a Doctor** link on the home page. Choose the location for your search. From the **All Plans** icon, select the Blue Care Network (HMO and POS plans) plan option.

Do I need a primary care physician and referrals?

All covered members will need an assigned primary care physician (PCP). This is done directly with Blue Care Network. Simply assign a PCP through your member secured services portal, or by calling customer service at 800.662.6667. Each family member can have their own PCP. Referrals are required to seek care from a specialist.

What is an HSA?

A high deductible health plan, such as this, allows members who meet eligibility, to open and contribute to a tax-free bank account called a Health Savings Account (HSA). Funds deposited in an HSA bank account can be used to help pay for eligible medical, prescription, dental and/or vision expenses for themselves and their IRS tax dependents.

Am I eligible to open and contribute to an HSA Bank Account?

To confirm if you are eligible to contribute to an HSA bank account, please review the below:

You must be enrolled in an HSA qualified health plan	You cannot have or be eligible to use a full purpose FSA
You cannot be enrolled in any other non-HSA health plan	You cannot be enrolled in Medicare, Medicaid or TriCare
You cannot be claimed as a dependent on another person's tax returns	You must not have used VA benefits in the past 3 months, with the exception of preventive care or a service-related disability

Do I need to open an HSA Bank Account?

Oxford Community Schools partners with UMB (www.hsa.umb.com) for employees who are eligible for an HSA bank account. If you need to open an HSA account, please see the directions to do so on the UMB handout.

How does an HSA medical plan work?

All services, both medical and prescription, apply to the deductible first. If you cover just yourself, your deductible is $1,400. If you cover yourself and at least one other person, your deductible is $2,800 total. Your applicable deductible can be met all in medical services, all in prescription services, or a combination of both.

How are my medical services covered once my deductible has been satisfied?

Blue Care Network will begin to pay for 100% of the cost for most approved medical services after your applicable deductible has been satisfied within a plan year. Some select services will only be covered at 50%. This is called coinsurance.

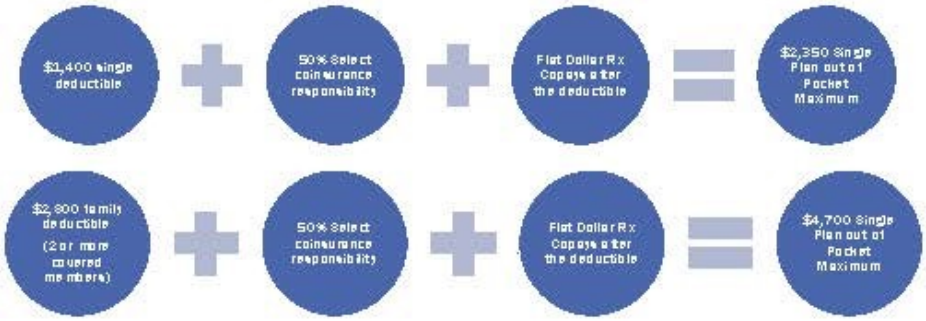
The information above is intended as an easy to read explanation of your coverage. If a discrepancy is found your Summary Plan Description (SPD) will govern.

How are my prescription services covered once my deductible has been satisfied?

Prescriptions will be assigned a flat dollar copay amount for a 30-day supply once your applicable deducible has been satisfied within a plan year.

What is the plan out of pocket maximum?

The plan out of pocket maximum is $2,350 if you cover just yourself, and $4,700 if you cover yourself and at least one other person The $2,350 includes the total single deductible of $1,500, your select 50% coinsurance responsibility for approved medical services, and flat dollar copayments for prescription drugs once the deductible has been met.



What happens if I reach the plan out of pocket maximum?

If you reach your single out of pocket maximum of $2,350 within a plan year, all other approved services for the remainder of the plan year will be covered at 100%. If your covered family (2 or more members) reaches the $4,700 out of pocket maximum within a plan year, all other approved services for the remainder of the plan year will be covered at 100% for all covered members.

A few tips and tricks...

- You can change your Primary Care Physician at any time
- An OBGYN is not considered a specialist for preventive services, therefore no referral is needed
- A Pediatrician is not considered a specialist and can be assigned as a primary care physician for your child
- Prescription medication costs can vary by pharmacy
- One person can satisfy the entire family deductible and out of pocket maximum for their family
- Prepaying for hospital services is not recommended and can cause confusion during the claims process. Simply tell your provider that you have an HSA medical plan and wait for services to fully process with Blue Care Network
- Always review and compare your Explanation of Benefits documents from Blue Care Network to your provider invoices, they should match
- You still have access to emergent and urgent care coverage while traveling nationwide
- Emergencies are covered worldwide. Depending on your location, you may have to pay out of pocket for care and submit documentation for reimbursement
- You can create an online secured account and download a secure mobile app for coverage information on the go

Still need help throughout the year?

Contact Human Resources or Beth Bishoff at Gallagher. She can be reached at beth_bishoff@ajg.com or via phone/text directly at 313.570.7310.

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You've made the decision to enroll in the Blue Care Network $3,000 HSA plan, now what?

How do I find providers?

To locate a provider, you can visit www.BCBSM.com. Click on the **Find a Doctor** link on the home page. Choose the location for your search. From the **All Plans** icon, select the Blue Care Network (HMO and POS plans) plan option.

Do I need a primary care physician and referrals?

All covered members will need an assigned primary care physician (PCP). This is done directly with Blue Care Network. Simply assign a PCP through your member secured services portal, or by calling customer service at 800.662.6667. Each family member can have their own PCP. Referrals are required to seek care from a specialist.

What is an HSA?

A high deductible health plan, such as this, allows members who meet eligibility, to open and contribute to a tax-free bank account called a Health Savings Account (HSA). Funds deposited in an HSA bank account can be used to help pay for eligible medical, prescription, dental and/or vision expenses for themselves and their IRS tax dependents.

Am I eligible to open and contribute to an HSA Bank Account?

To confirm if you are eligible to contribute to an HSA bank account, please review the below:

You must be enrolled in an HSA qualified health plan	You cannot have or be eligible to use a full purpose FSA
You cannot be enrolled in any other non-HSA health plan	You cannot be enrolled in Medicare, Medicaid or TriCare
You cannot be claimed as a dependent on another person's tax returns	You must not have used VA benefits in the past 3 months, with the exception of preventive care or a service-related disability

Do I need to open an HSA Bank Account?

Oxford Community Schools partners with UMB (www.hsa.umb.com) for employees who are eligible for an HSA bank account. If you need to open an HSA account, please see the directions to do so on the UMB handout.

How does an HSA medical plan work?

All services, both medical and prescription, apply to the deductible first. If you cover just yourself, your deductible is $3,000. If you cover yourself and at least one other person, your deductible is $6,000 total. Your applicable deductible can be met all in medical services, all in prescription services, or a combination of both.

How are my medical services covered once my deductible has been satisfied?

Blue Care Network will begin to pay for 100% of the cost for most approved medical services after your applicable deductible has been satisfied within a plan year. Some select services will only be covered at 50%. This is called coinsurance.

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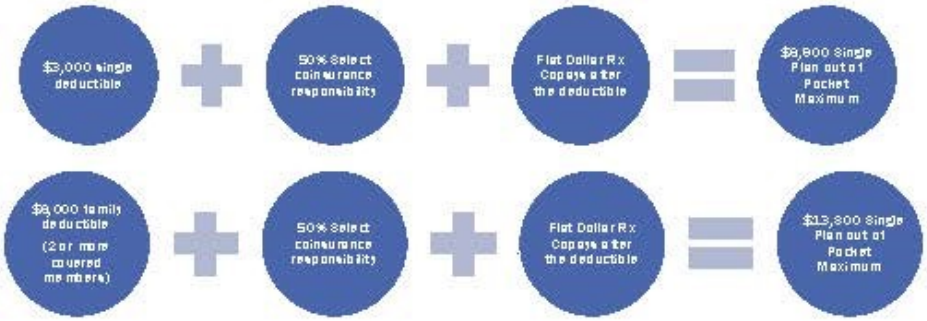
How are my prescription services covered once my deductible has been satisfied?

Prescriptions will be assigned a flat dollar copay amount for a 30-day supply once your applicable deducible has been satisfied within a plan year.

What is the plan out of pocket maximum?

The plan out of pocket maximum is $6,900 if you cover just yourself, and $13,800 if you cover yourself and at least one other person The $6,900 includes the total single deductible of $3,000, your select 50% coinsurance responsibility for approved medical services, and flat dollar copayments for prescription drugs once the deductible has been met.



What happens if I reach the plan out of pocket maximum?

If you reach your single out of pocket maximum of $6,900 within a plan year, all other approved services for the remainder of the plan year will be covered at 100%. If your covered family (2 or more members) reaches the $13,800 out of pocket maximum within a plan year, all other approved services for the remainder of the plan year will be covered at 100% for all covered members.

A few tips and tricks...

- You can change your Primary Care Physician at any time
- An OBGYN is not considered a specialist for preventive services, therefore no referral is needed
- A Pediatrician is not considered a specialist and can be assigned as a primary care physician for your child
- Prescription medication costs can vary by pharmacy
- One person can satisfy the entire family deductible and out of pocket maximum for their family
- Prepaying for hospital services is not recommended and can cause confusion during the claims process. Simply tell your provider that you have an HSA medical plan and wait for services to fully process with Blue Care Network
- Always review and compare your Explanation of Benefits documents from Blue Care Network to your provider invoices, they should match
- You still have access to emergent and urgent care coverage while traveling nationwide
- Emergencies are covered worldwide. Depending on your location, you may have to pay out of pocket for care and submit documentation for reimbursement
- You can create an online secured account and download a secure mobile app for coverage information on the go

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You've made the decision to enroll in the Blue Care Network $5,000 HRA plan, now what?

How do I find providers?

To locate a provider, you can visit www.BCBSM.com. Click on the Find a Doctor link on the home page. Choose the location for your search. From the All Plans icon, select the Blue Care Network (HMO and POS plans) plan option.

Do I need a primary care physician and referrals?

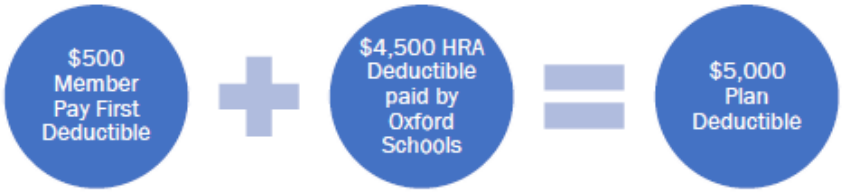
All covered members will need an assigned primary care physician (PCP). This is done directly with Blue Care Network. Simply assign a PCP through your member secured services portal, or by calling customer service at 800.662.6667. Each family member can have their own PCP. Referrals are required to seek care from a specialist.

What does an HRA mean?

In simple terms, this medical plan has a very large deductible. Instead of you being responsible for the entire deductible, Oxford Schools helps share in the cost!

How does an HRA work?

This plan has a $5,000 deductible per person, not to exceed $10,000 as a family. You are only responsible for the first $500 of the plan's $5,000 deductible per person. Oxford Schools pays the remaining $4,500 of the plan's deductible per person not to exceed $9,000 as a family.



Does this plan have coinsurance?

Yes. Blue Care Network will begin to pay for 80% of the cost of approved medical services after the total $5,000 plan deductible (both your $500 responsibility, and Oxford Schools' $4,500 portion) has been satisfied, leaving the other 20% for you to pay.

Does the HRA help share in the cost of the 20% coinsurance responsibility for medical services which applies after the deductible?

No. The HRA funds provided by Oxford Schools apply to deductible expenses only.

Do flat dollar copays for office visits or prescriptions drugs apply to the plan deductible or coinsurance?

No, they do not, however they do apply to the total plan out of pocket maximum.

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What is the plan out of pocket maximum?

The plan out of pocket maximum is $6,350 per person, not to exceed $12,700 as a family. The $6,350 includes the total plan deductible of $5,000 (both your $500 responsibility and Oxford Schools' $4,500 portion), your 20% coinsurance responsibility for approved services, and flat dollar copayments for office visits and prescription drugs.

What is the my out of pocket maximum?

Your out of pocket maximum is $1,850 per person, not to exceed $3,700 as a family. The $1,850 includes your portion of the deductible, your 20% coinsurance responsibility for approved services, and flat dollar copayments for office visits and prescription drugs.

What happens if I reach the plan out of pocket maximum?

If you reach your individual plan out of pocket maximum of $6,350 (including the $4,500 deductible portion paid by Oxford Schools) within a plan year, all other approved services for the remainder of the plan year will be covered at 100%. If your covered family (2 or more members) reaches the $12,700 plan out of pocket maximum (including the $9,000 deductible portion paid by Oxford Schools) within a plan year, all other approved services for the remainder of the plan year will be covered at 100%.

A few tips and tricks...

- You can change your Primary Care Physician at any time
- An OBGYN is not considered a specialist for preventive services, therefore no referral is needed
- A Pediatrician is not considered a specialist and can be assigned as a primary care physician for your child
- There is no action required on your part to initiate HRA payments from Oxford Schools. This happens behind the scenes with Blue Care Network
- Prepaying for hospital services is not recommended and can cause confusion during the claims process. Simply tell your provider that you have an HRA medical plan and wait for services to fully process with Blue Care Network
- Always review and compare your Explanation of Benefits documents from Blue Care Network to your provider invoices, they should match
- You still have access to emergent and urgent care coverage while traveling nationwide
- Emergencies are covered worldwide. Depending on your location, you may have to pay out of pocket for care and submit documentation for reimbursement
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You've made the decision to enroll in the Blue Cross Blue Shield $1,400 HSA plan, now what?

How do I find providers?

To locate a provider, you can visit www.BCBSM.com. Click on the **Find a Doctor** link on the home page. Choose the location for your search. From the **All Plans** icon, select the PPO Plans plan option.

Do I need a primary care physician and referrals?

No, you do not. While most members seek care from a primary physician, it is not required to designate one. You are also not required to obtain a referral to seek specialty care. It's recommended to always seek care from in-network participating providers.

What is an HSA?

A high deductible health plan, such as this, allows members who meet eligibility, to open and contribute to a tax-free bank account called a Health Savings Account (HSA). Funds deposited in an HSA bank account can be used to help pay for eligible medical, prescription, dental and/or vision expenses for themselves and their IRS tax dependents.

Am I eligible to open and contribute to an HSA Bank Account?

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Do I need to open an HSA Bank Account?

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How does an HSA medical plan work?

All services, both medical and prescription, apply to the deductible first. If you cover just yourself, your deductible is $1,400. If you cover yourself and at least one other person, your deductible is $2,800 total. Your applicable deductible can be met all in medical services, all in prescription services, or a combination of both.

How are my medical services covered once my deductible has been satisfied?

Blue Cross Blue Shield will begin to pay for 100% of the cost for most approved medical services after your applicable deductible has been satisfied within a plan year. Some select services will only be covered at 50%. This is called coinsurance.

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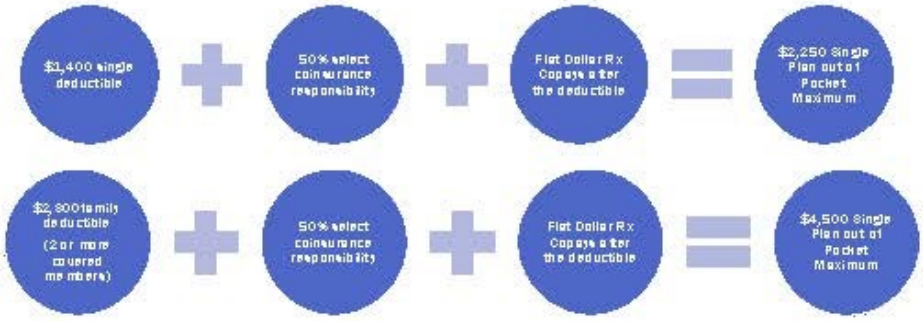
How are my prescription services covered once my deductible has been satisfied?

Prescriptions will be assigned a flat dollar copay amount for a 30-day supply once your applicable deducible has been satisfied within a plan year.

What is the plan out of pocket maximum?

The plan out of pocket maximum is $2,250 if you cover just yourself, and $4,500 if you cover yourself and at least one other person The $2,250 includes the total single deductible of $1,500, your 20% coinsurance responsibility for approved medical services, and flat dollar copayments for prescription drugs once the deductible has been met.



What happens if I reach the plan out of pocket maximum?

If you reach your single out of pocket maximum of $2,250 within a plan year, all other approved services for the remainder of the plan year will be covered at 100%. If your covered family (2 or more members) reaches the $4,500 out of pocket maximum within a plan year, all other approved services for the remainder of the plan year will be covered at 100% for all covered members.

A few tips and tricks...

- Prepaying for hospital services is not recommended and can cause confusion during the claims process. Simply tell your provider that you have an HSA medical plan and wait for services to fully process with Blue Cross Blue Shield.
- Prescription medication costs can vary by pharmacy
- One person can satisfy the entire family deductible and out of pocket maximum for their family
- Always review and compare your Explanation of Benefits documents from Blue Cross Blue Shield to your provider invoices, they should match.
- Emergencies are covered worldwide. Depending on your location, you may have to pay out of pocket for care and submit documentation for reimbursement.
- You can create an online secured account and download a secure mobile app for coverage information on the go!

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BLUE CROSS ONLINE VISITS

Blue Cross
Online Visits℠

Virtual care that's always there

Convenient and affordable medical and behavioral health care you can trust

With Blue Cross Online Visits℠, you and everyone on your health care plan can get virtual medical and behavioral health care on your smartphone, tablet or computer.

Blue Cross Online Visits are included with your Blue Cross health care plan.

MEDICAL

Have a virtual visit with a U.S. board-certified doctor or nurse practitioner for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. And, it's easy to find providers who specialize in children with the *Children's Medical* feature.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time to see a provider is five minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

BEHAVIORAL HEALTH

Through the *Therapy* and *Psychiatry* options, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety or depression.

An appointment is needed for virtual behavioral health visits. Many providers offer extended hours, including nights and weekends.

Start a visit or sign up today

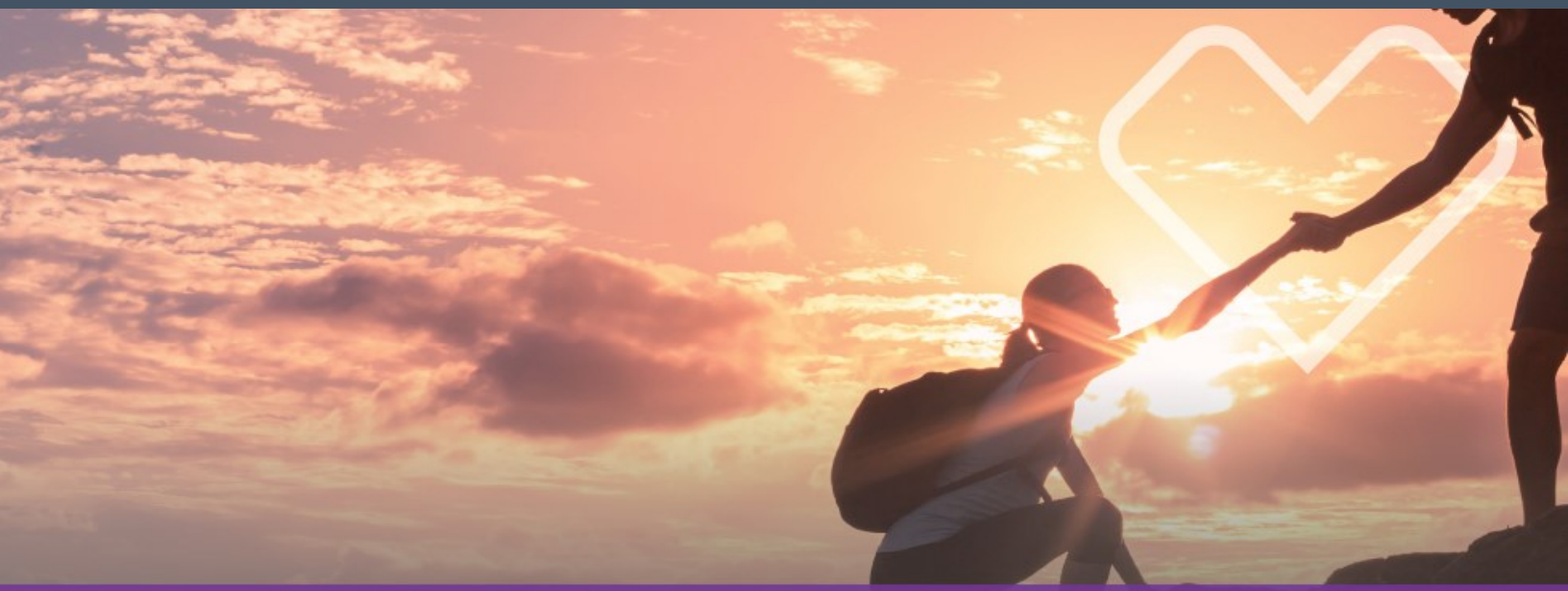
Download the BCBSM Online Visits℠ app
or visit **bcbsmonlinevisits.com**

Family members ages 18 and older will need to create their own accounts. When updating or creating your account, choose your plan name and enter your enrollee ID so your coverage is applied correctly. Call 1-844-606-1608 with any questions about your account.

Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

EAP



Anytime support
School Employee Guidance Program

Program name
To access services:
1-888-866-4827 / TTY: 711
ResourcesForLiving.com
Username: Oxford
Password: SEGP

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support

You can access up to 7 counseling sessions each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face, online, televideo or by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- School and financial aid research
- Special needs
- Pet care
- Community resources/ basic needs
- Home repair and improvement
- Summer programs for kids
- Household services and more

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EAP

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Civil/Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee and eligible household members.

Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

Discount Center
Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Educator resources
Explore articles and ideas related to topics such as classroom management, social and emotional learning, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder, stress and more.

myStrength™
myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

Additional services

Chat therapy — Send secure text messages to your counselor, who will respond within one working day up to five days a week. A week of texting counts as one session. You can also schedule to meet online for 30-minute televideo sessions. Each televideo session counts as one visit. Work on the same kinds of issues you'd see a counselor face-to-face to talk about.

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

MindCheck — Online tools that make it easy to improve your emotional wellbeing. Measure your mindset and get feedback and resources to maintain a positive outlook.

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Aetna Resources For Living℠ is the brand name used for products and services offered through the Aetna group of subsidiary companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC. and in California for Knox-Keene plans, Health and Human Resources Center, Inc.

All EAP calls are confidential, except as required by law. Discount services are provided and managed by Lifecare, an independent third party. Aetna does not oversee or control the services provided by or recommended by Lifecare and does not assume any liability for their services. EAP instructors, educators and participating providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. For more information about Aetna plans, go to **aetna.com**.

HEALTH SAVINGS ACCOUNT

HSA Eligibility

To be eligible to make deposits to an HSA, the account holder:

- Must be currently enrolled in an HSA-qualified health plan
- May not be enrolled in any other non-HSA qualified health plan
- May not have, or be eligible to use, a general purpose flexible spending account (FSA)
- Cannot be claimed as a dependent on another person's tax return
- May not be enrolled in Medicare, Medicaid or Tricare
- Must not have used VA medical benefits in the past three months, with the exception of preventative services or treatment for a service-connected disability

Contributions to your HSA

The annual maximum allowable contributions to an HSA, as established by the IRS, for 2023 are $3,850: Individual and $7,750: Family.

Individuals 55 and older can make an additional catch-up contribution of $1,000 in 2023. A married couple can make two catch-up contributions if both spouses are eligible. The spouses must deposit the catch-up contributions into separate accounts.

The annual maximum contribution is based on a calendar year and there is no limit to the dollar balance that can build in the account over time. Contributions can come from:

- Employee pre-tax payroll withholding
- Employer contributions (non-taxable income)
- Individual contributions from account owner or other individual (tax-deductible for account holder)
- IRA or Roth IRA rollover

Distributions from your HSA

You, or an authorized signer, can make withdrawals (or distributions) for qualified expenses.

Distributions from your HSA can be made by check, debit card, ATM, online bill payment or by in-person request.

Distributions for qualified medical expenses are tax free.

Distributions made for anything other than qualified medical expenses are subject to IRS tax plus a 20% penalty. The penalty is waived if the account owner is 65 or older, or due to death or disability.

Qualified medical expenses for your spouse and

Advantages of an HSA

Portability

You can take 100% of the deposited funds with you when you retire or change employers. You are the account owner.

Flexibility

You can choose whether to spend the money on current medical expenses, or you can save your money for future use. Unused funds remain in the account from year to year and there is no "use it or lose it" provision.

Tax Savings

Contributions are tax free (pre-tax through payroll deductions or tax deductible). Earnings are tax free. Funds withdrawn for eligible medical expenses are tax free.

Premium Savings

An HSA-qualified insurance plan tends to be less expensive than a traditional insurance plan.

FLEXIBLE SPENDING ACCOUNT (FSA)

The FSA administrator is TASC

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

As you know, health care and day care expenses can really add up. Flexible Spending Accounts give you a way to pay for these expenses with tax-free dollars because you bypass taxes, you save money.

There are two types of accounts and they are separate accounts and CANNOT be used together.

Health Care Flexible Spending Account
Up to a $3,050 annual election

Dependent Care Flexible Spending Account
Up to a $5,000 annual election

Advantages of an FSA

You may choose to participate in one or both of these options depending on your individual needs.

Flexible Spending Accounts allow you to save money because your contributions to the accounts are deducted from your pay before Federal and Social Security taxes are calculated. The amount of savings you will enjoy by participating in a Flexible Spending Account will depend on your individual tax bracket and the amount of money that is withheld from your paycheck on a tax-free basis.

The Health Care Flexible Spending Account is designed to help you pay for health expenses that are not covered by your basic health plan, including deductible amounts you have to pay and copays or co-insurance amounts required by your insurance plan. Qualified eligible expenses also include many expenses that may not covered by your vision or dental plan. **Please see the IRS website for more details**

ADDITIONAL BENEFITS

OXFORD COMMUNITY SCHOOLS offers several additional benefits through Guardian that ensure you and your family have valuable coverage. Please refer to your collective bargaining agreement for eligibility and coverage details.

LIFE & AD&D INSURANCE

Benefits Administered through Guardian

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Oxford Community Schools.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. This coverage is in addition to your company-paid life insurance.

LONG TERM DISABILITY INSURANCE

Oxford Community Schools also provides Long Term disability insurance. This benefit replaces a portion of your income if you are unable to work as a result of a non-job illness or injury.

Guardian®

VISION INSURANCE

Insurance for vision helps protect the health of your eyes. How? Vision insurance plans cover routine eye examinations and help pay for glasses, frames, and contact lenses. Regular eye examinations are also important for general health because they can detect diseases like glaucoma and diabetes.

DENTAL INSURANCE

Oxford provides dental coverage including cleanings. A dental exam can be an important way to detect underlying medical conditionals before they become a major issue.

LEGAL 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.

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.

Newborns' and Mothers' Health Protection Act Notice

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

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

Women's Health & Cancer Rights Act

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the plan:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The plan will determine the manner of coverage in consultation with you and your attending doctor. 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. If you would like further information about the Women's Health & Cancer Rights Act, please contact Human Resources.

OXFORD COMMUNITY SCHOOLS

("PLAN SPONSOR")
HIPAA NOTICE OF PRIVACY PRACTICES

UPDATED DATE: 1/1/2023

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR PLAN SPONSOR (YOUR EMPLOYER WHO SPONSORS YOUR GROUP HEALTH PLAN) CAN USE OR DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) place important restrictions on sharing your medical information and provide you with important privacy rights. This Notice of Privacy Practices (the "Notice") replaces all prior notices provided by the Plan Sponsor and is effective on the Date Distributed noted above. This Notice describes the legal obligations of the Plan Sponsor and your legal rights regarding your "protected health information" ("PHI") held by your Plan Sponsor and Group Health Plan. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or other purposes permitted by law.

Generally, PHI includes your personal information collected from you or created by your Group Health Plan, or the Plan Sponsor on behalf of a Group Health Plan, that relates to your past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care, and includes your elections to enroll in the Plan. If you have any questions about this Notice or about our privacy practices, please contact your Privacy Officer identified below.

The Plan Sponsor may retain agents, service providers and third-party administrators to administer all or part of your Group Health Plan such as claims payment and enrollment management. The term Plan Sponsor as used in this Notice includes all entities that provide services related to your Group Health Plan that have access to your PHI. The Plan Sponsor and contracted service providers are required by law to follow the terms of this Notice.

The Plan Sponsor is required by law to maintain the privacy of your PHI, provide you with certain rights with respect to your PHI, provide you with a copy of this Notice, and follow the terms of this Notice. The Plan Sponsor reserves the right to change the terms of this Notice and its practices regarding your PHI. If there is any material change to this Notice, the Plan Sponsor will provide you with a copy of the revised Notice of Privacy Practices.

Use and Disclosure

The Plan Sponsor may use or disclose your PHI under certain circumstances without your permission. All of these certain circumstances will fall within one of the categories listed below.

- **For Treatment,** to facilitate medical treatment or services by providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment,** to determine your eligibility for Plan benefits, to facilitate payment for the treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.
- **For Health Care Operations,** uses and disclosures necessary to run the Plan.
- **Treatment Alternatives or Health-Related Benefits and Services** that might be of interest to you.
- **To Business Associates** to perform various functions on our behalf or to provide certain types of services. A Business Associate will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan Sponsor to implement appropriate safeguards regarding your PHI.
- **As Required by Law** when required to do so by federal, state, or local law.

HI-5130-030821

The information in this communication is confidential and may be used by the authorized recipient only for its intended purpose. Any other use or disclosure is prohibited.

- **To Avert a Serious Threat to Health or Safety** to you, or the health and safety of the public, or another person, limited to someone able to help prevent the threat.

In addition, the following categories describe other ways that the Plan Sponsor may use and disclose your PHI without your specific authorization. All of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation,** after your death to an organization that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military,** if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation** or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks** for public health activities. These activities generally include the following:
  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities** for activities authorized by law. For example, audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes** in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- **Law Enforcement** if asked to do so by a law-enforcement official:
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain the victim's agreement;
  - about a death that the Plan Sponsor believes may be the result of criminal conduct; and
  - about criminal conduct.

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- **Coroners, Medical Examiners, and Funeral Directors,** for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- **National Security and Intelligence Activities** to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Research,** to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The Plan Sponsor is required to disclose your PHI to:

- **Government Audits** to the Security of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to Yo** on your request, the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

Other Disclosures

The Plan Sponsor may disclose your PHI to:

- **Personal Representatives** authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Comply with your Authorization.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Privacy Rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Privacy Officer identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer identified below.

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The information in this communication is confidential and may be used by the authorized recipient only for its intended purpose. Any other use or disclosure is prohibited.

- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer identified below. In addition, you must provide a reason that supports your request. the Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
    - is not part of the medical information kept by or for the Plan;
    - was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
    - is not part of the information that you would be permitted to inspect and copy; or
    - is already accurate and complete.

  If your request is denied, you have the right to file a statement of disagreement with the Plan Sponsor and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request 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 provided free of charge. For additional lists, the Plan Sponsor may charge you for the costs of providing the list. The Plan Sponsor will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions or limitation on your PHI** that the Plan Sponsor uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. Except as provided in the next paragraph, the Plan Sponsor is not required to agree to your request. However, the Plan Sponsor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Privacy Officer identified below. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply - for example, disclosures to your spouse. If the Plan Sponsor honors the request, it will stay in place until you revoke it or the Plan Sponsor notifies you.

- **Right to Request Confidential Communications** about medical matters in a certain way or at a certain location. For example, you can ask that the Plan Sponsor only contact you at work or by mail. Your request must be made in writing to the Privacy Officer identified below and specify how or where you wish to be contacted. The Plan Sponsor will accommodate all reasonable requests.

- **Right to Be Notified of a Breach** in the event that the Plan Sponsor (or a Business Associate) discover a breach of unsecured PHI.

- **Right to a Paper Copy of This Notice.** You may request a paper copy of this notice at any time from the Privacy Officer identified below, even if you have agreed to receive this notice electronically.

HI-5130-030821

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact:

Company:	OXFORD COMMUNITY SCHOOLS
Title:	Privacy Officer
Address:	10 N. Washington St
	Oxford, MI 48371
Phone:	248-969-5029

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HI-5130-030821

The information in this communication is confidential and may be used by the authorized recipient only for its intended purpose. Any other use or disclosure is prohibited.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care 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 HR

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the

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 Oxford Community Schools		4. Employer Identification Number (EIN) 38-6003081
5. Employer address 10 N. Washington		6. Employer phone number 248-969-5029
7. City Oxford	8. State MI	9. ZIP code 48371
10. Who can we contact about employee health coverage at this job? Kelly Abraham		
11. Phone number (if different from above)	12. Email address Kelly.Abraham@oxfordschools.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:

    Working 30 hours or more

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouses and children 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.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
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	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – 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: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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	**SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**

Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Creditable Coverage Notice

Important Notice from Oxford Community Schools

About Your Prescription Drug Coverage and Medicare

IMPORTANT NOTE:

IF YOU (AND ALL OF YOUR DEPENDENTS) ARE NOT ELIGIBLE FOR MEDICARE,

YOU MAY DISREGARD THIS NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oxford 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. Oxford Community Schools has determined that the prescription drug coverage offered by the Oxford 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.

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 Oxford Community 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 Oxford Community 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?

You should also know that if you drop or lose your current coverage with Oxford 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

Creditable Coverage Notice

Important Notice from Oxford Community Schools

About Your Prescription Drug Coverage and Medicare Continued

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 Oxford Community Schools changes. You also may request a copy of this notice at any time.

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

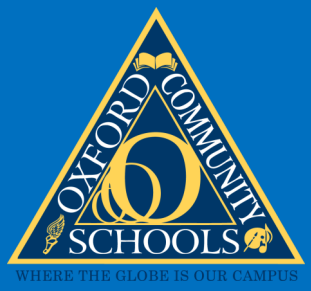
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription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

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

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

Remember:

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



This benefit summary prepared by

Insurance | Risk Management | Consulting

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

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