2024 – 2025 Plan Year
SDST Open Enrollment Newsletter

Highlights of your 2024 – 2025 Benefits Offerings:

- **Medical:** We will continue to provide medical plan options through Independence Blue Cross (IBC). No changes to the plan.
- **Rx:** Prescription drug benefits will continue to be administered by CapitalRx. Mail Order and Specialty Drug will change from Costco to OptumRx through CapitalRx.
- **Dental:** United Concordia will continue to manage the dental benefit. Dependent children may now continue on your plan until age 26. Enrollment full-time in college is no longer required.
- **Flexible Spending Accounts (FSAs):** Remember to elect your FSA plan participation and amounts if you wish to participate this year. Further details inside.
- **Voluntary Benefits:** Further details inside.
- **Contribution Rates:** Further details inside.

In this Issue:

Open Enrollment Period:

May 6, 2024 – May 17, 2024

Or 30 days after your start date/life event

Our annual Open Enrollment period is your opportunity to review your benefits and make any changes for the year ahead. During this year's Open Enrollment, you will learn about your options, evaluate your needs, and choose the benefits that will protect you (and your eligible family members) for a full year.

We are committed to offering you:

- Quality benefit choices designed to meet your needs and the needs of your family
- Tax advantages — pre-tax payroll deductions

Health benefits remain one of the most valuable components of any employee compensation program. As in the past, the School District of Springfield Township (SDST) is dedicated to offering you a comprehensive benefit plan.

Qualified Life Events

The choices you make during Open Enrollment will be in effect for the 12-month plan year from July 1, 2024 – June 30, 2025. However, you may make changes during the year if you experience a qualified life event. **If you need to report a life event during the year, you will need to contact Human Resources with the necessary changes within 31 days of the event and changes will be effective the date of the event.** Some examples of life events are:

- Birth or adoption of a child
- Marriage
- Divorce and/or legal separation
- Death or loss of a dependent (including loss of dependent status)
- Change in your spouse's employment status causing loss or gain of benefits coverage
- Change in your own employment status
- Change in residence that affects the benefits offered to you
- Eligibility for Medicare
- Offer of coverage elsewhere

Eligibility & Enrollment

Dependent Eligibility

You may enroll your eligible dependents when you enroll yourself. Proof of dependent eligibility will be requested when enrolling a spouse or child. Dependents who are eligible for benefit coverage include:

- ✓ Your legally married spouse
- ✓ Your dependent children

Included in the definition of dependent child(ren) are:

- Your naturally born child(ren), legally adopted child(ren), step-child(ren), or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian
- For medical insurance, your dependent child(ren), up to age 26 whether they are a full-time student or not. Coverage ends at the end of the month following the date they turn 26. For dental insurance, your dependent child(ren), effective 7/1/2024, they can remain on your plan up to age 26 just like medical insurance!

Overview of all Medical and Prescription Drug Rate Changes Effective 7/1/2024

Premium Contribution Rate Changes:

- For Full-time Professional, Confidential, Administrator, Athletic Trainer and Support Class A & B:
  - Employee contribution to Core Plan (Keystone) medical remain at 16%.
  - Employee contribution to Personal Choice HDHP w/HSA plan medical only remain at 9%.
- For Support Class C Aides :
  - The employer contribution remains at $6000.
- For Support Class C All Others:
  - The employer contribution remains at $1200.
- For Support Class D:
  - The employer contribution remains at $0.

HSA Contribution Stays the Same:

- For Professional, Confidential, Administrator, Athletic Trainer and Support Class A, B & C:
  - SDST will contribute $500 for single and $1000 for Adult/Child, Adult/Children, Two Adults or Family.
- For Support Class D
  - SDST will not be contributing to your HSA.

IMPORTANT:

Please take this time to review all your benefits and confirm that the dependent information on file is current. Your benefit elections will remain in effect for the 2024 – 2025 fiscal year.

This Open Enrollment newsletter covers only the highlights of Springfield Township's employee benefits program. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. Springfield Township intends to continue these programs, but reserves the right to change or end them at any time through negotiations with the appropriate parties. Participation in the programs does not imply a contract of employment.

Virtual Enrollment Process

We are excited to continue our simplified virtual enrollment process this year! You have 2 enrollment options: simply complete your enrollment online via the benefit system by yourself **OR** you can schedule an appointment with a benefits counselor who will walk you through your benefit choices and associated costs, answer any questions you have, and help you enroll virtually in the elections that best meet the needs of you and your family.
NOTE: All employee and dependent information is protected and will be in the virtual enrollment system prior to meeting with benefit counselors!

OPTION 1: Self-Enrollment

Step 1: Go to: https://sdst.mybenefitsinfo.com/ and click on "Click here to enroll in your benefits without assistance."

Step 2: Fill in your username and password.

Employee ID: please enter your Employee ID or Social Security Number (SSN).

PIN: Is a combination of the last 4 digits of your SSN, and the last two digits of your birth year. For example:

Date of Birth: January 7, 1972

SNN: 123-45-6789

PIN Number: 678972

Please take note of this as you will also need your PIN to complete and sign your enrollment form if you make any changes due to a qualifying life event.

Step 3: Complete all screens making your selections and signing with your PIN at the very end.

If you have questions about your benefits, need login assistance or navigation assistance, contact the Open Enrollment Call Center at 1-800-735-0080. Benefit specialists will be available from May 6 to May 17, Monday – Friday 8am to 5pm.

OPTION 2: Assisted Enrollment

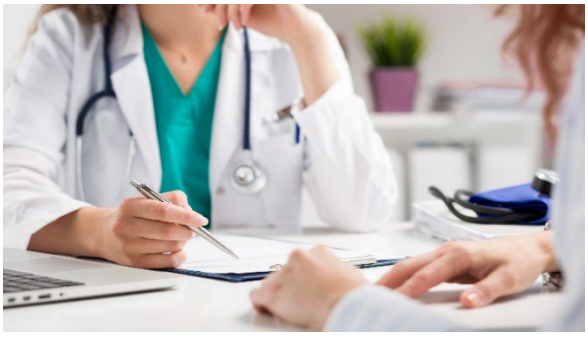
Call Center Enrollment Information:

Once again, we are partnering with U.S. Enrollment Services to assist in our Open Enrollment and have contracted for their Call Center and Co-Browsing support. The benefits specialist will be trained on all benefit programs available to district employees and will be able to answer questions regarding your programs. They will review your current elections and will assist you in making changes or modifications to benefit programs for the upcoming Plan Year. You will simply make an appointment online to set a convenient time to speak to the representative.

- *To schedule your appointment please go to: https://sdst.mybenefitsinfo.com/ or call **800-735-0080** for assistance.*
- *Once you schedule your appointment time, you will receive a confirmation email and a reminder email the day prior to your appointment.*

What to expect during my appointment:

Your appointment with the Benefits Specialist is scheduled for 30 minutes. During this time, they will verify all demographic and dependent information, as well as discuss each benefit program with you. This is your annual opportunity to review and ask questions regarding any of your benefit programs. If you are at a computer or mobile device with internet access, the Benefit Specialist can share their screen (Co-browse) as they walk through the enrollment system. They will provide instructions at the time of your call.



Independence Blue Cross Medical Plans

Springfield Township will continue to provide you with medical benefits through Independence Blue Cross (IBC). All 3 plans are available for Professional, Confidential, Athletic Trainer, Administrative and Support Staff Class A and B. The plans available for Support Staff Class C and D are Keystone POS C2F201 and Personal Choice HDHP with HSA. The plan options provide you with enhanced benefits and services at a reasonable cost. You may view all Summary of Benefits for each plan on the Human Resources Google Intranet Site. Please note that any deductible or maximums will accrue on a fiscal/school year (July through June).

Keystone Point of Service Plan

The Point-of-Service (POS) plan is a managed care program that gives you freedom to select any doctor or hospital, in or out of the network, without a referral. You must select a Primary Care Physician (PCP) for yourself and each family member, then each time you need medical care, you decide whether to use referred or self-referred care. For example, if you require specialty care, you may choose to get a referral from your PCP or self-refer to a provider of your choice. However, if you choose to go out of the network, the plan will often pay less and you will have to pay more under the plan, you must select a PCP and referrals are required for some services.

Personal Choice PPO

The Personal Choice PPO plan gives you the freedom to choose your own doctors or hospitals. You will maximize your coverage by choosing participating providers within the BlueCard® PPO program. Under the Personal Choice PPO plan, you do not need to select a Primary Care Physician (PCP) or need to obtain a referral for services. However, if you receive care from a provider out of the Personal Choice network, the plan pays a lower percentage of covered services and you will have higher out-of-pocket expenses, such as higher copays.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

The HDHP is a preferred provider organization plan that utilizes IBC's national BlueCard PPO network. Your medical plan options provide you with direct access to in- and out-of-network providers and no referrals are required under this plan. However, if you choose to see a non-network provider, your out-of-pocket costs will be higher.

When you enroll in the HDHP, you will be automatically enrolled in a Health Savings Account (HSA). The district may contribute into this account for you based on your employee classification. In addition, you will have the option to open and contribute pretax dollars into this personal health savings account. You may then use your funds to pay for qualified medical expenses or save the money in your interest-bearing HSA. Any funds you don't use accumulate indefinitely and will grow the account for future qualified medical expenses. There is no "use it or lose it" rule.

Women's Preventive Health Care

The health care reform law (Affordable Care Act) requires health plans to cover certain preventive care services for women without any cost-sharing, such as deductibles, copayments or coinsurance. The following items are included in this coverage:

- Well-woman visits (annual preventive care visit in which adult women obtain recommended preventive services)
- Gestational diabetes screening for women 24 to 28 weeks pregnant, and women at high risk
- Human papillomavirus (HPV) testing for women 30 and older, once every three years
- Annual counseling for HIV and sexually transmitted infections, plus annual HIV testing for all sexually active women
- Contraceptives and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

Be sure to check your plan's specific rules before receiving care. Though plans are required to provide these services charge, they do have the option of using cost-control measures, such as requiring you pay for a brand name drug if a comparable generic drug is available, or charging a copayment for preventive services received at out-of-network facilities.

Capital Rx Prescription Drug Coverage

When you enroll in a medical plan, you automatically receive prescription drug coverage through Capital Rx. The Pharmacy Management Formulary Program provides a defined list of FDA-approved medications chosen for their medical effectiveness and value. The formulary list includes both generic and brand-name drugs. Your share of the cost will always be less for drugs that are on the formulary list; however, coverage is available for many non-formulary drugs. The Pharmacy Management Formulary Program utilizes the Capital Rx network, where you can locate a participating pharmacy to fill your prescription. The formulary drug program is divided into copayment categories called tiers. The copays per tier depend on the plan you choose. To get an updated copy of the tiered formulary list of drugs, visit www.cap-rx.com.

Mandatory Mail Order and Specialty Drugs were provided through CapitalRx and Costco. Effective July 1, 2024, the new partner with CapitalRx is Optum. Information will be sent directly from CapitalRx to employees who have current prescriptions to transfer them to the new provider. All prescriptions will now be able to be tracked on www.cap-rx.com.

With Capital Rx as your prescription drug benefit manager, you will have access to:

- **Retail pharmacies.** A network of over 65,000 participating independent and chain pharmacies nationwide.
- **Convenient Home Delivery services through the Capital Rx Pharmacy.** You can have up to a 90-day supply of most maintenance medications delivered directly to you. Maintenance medications are those taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes.
- **Online resources.** You can go to www.cap-rx.com for useful health and benefit information, along with online pharmacy services.
- **Capital Rx Customer Service.** Representatives are available to you by phone 24 hours a day, 7 days a week. Pharmacists are also available around the clock for consultation.
- **Specialist Pharmacists.** These pharmacists are available 24/7 by phone to help you and your doctors make sure that your medications act safely together and work well for you. Each has had specialized training in the medications used to treat a specific long-term condition, such as diabetes, high blood pressure, and asthma.

Go Generic! Keep You and Your Wallet Healthy.

1. What are generic drugs?

Generic drugs are prescription medications that have the same active ingredients, dosage amounts, strength, safety, and quality as brand-name prescription medications.

2. Are generic drugs just as safe as brand-name drugs?

Yes. Laboratories that produce generic drugs must meet the same high FDA standards as the facilities of brand-name drugs, and all generic drugs are FDA-approved to be therapeutically equivalent to brand-name drugs.

3. Why are generic drugs less expensive?

When a new medicine is invented, a patent is filed so that no other company may reproduce that drug. While the patent is current, companies can charge a much higher price for the drug because there is no competition. In addition, companies often spend large amounts of money for advertising and promotion, further increasing the cost of the brand name medication.

When a medication's patent expires, other companies may produce this drug, creating generic medications. Due to increased competition, and because these other companies rarely spend money on advertising, the price of the generic drug is significantly lower.

4. What is different about generic?

The appearance of brand-name drugs is protected by law, so generic drugs will have different shapes, flavors, and/or colors. However, since the active ingredients are the same, they will work the same way in your body as the brand-name drug.

5. Does every brand-name drug have a generic drug equivalent?

No. Pharmaceutical companies have a patent on their brand-name medications, so new drugs will not have a generic equivalent until the patent expires.

6. What if my brand-name drug is not available in generic form?

Even if your brand name drug is not available in generic form, there may be a different generic drug that could work just as well. Ask your doctor if a therapeutic alternative might be right for you. A generic therapeutic alternative is the equivalent for a different brand-name drug and treats your condition using a different active ingredient. If your doctor agrees, you can feel confident about using the generic therapeutic alternative and feel good about saving money too!

Capital Rx | Optum

Capital Rx and Optum Home Delivery are working together to offer you affordable prescription medications, delivered right to your home.

Getting Started with Optum Home Delivery

Please reach out to your prescriber and update your mail order pharmacy provider as Optum Home Delivery.

ONLINE

Go to the Capital Rx Member Portal at https://app.cap-rx.com/login to register or log in. Select 'Home Delivery' to confirm your profile settings.

PHONE

Call Capital Rx and follow the prompts for 'medications delivered to your home' or ask your doctor to send an electronic prescription to Optum Home Delivery. A coordinator will reach out to get you set up.

Choose one of the following options to request refills of current prescriptions or send new prescriptions to Optum Home Delivery.

- **E-prescribe (preferred):** Have your prescriber electronically send your prescription to Optum Home Delivery.
- **Fax:** Have your prescriber fax your prescription to Optum Home Delivery. Faxed prescriptions may only be sent by a doctor's office and must include patient information.
- **Online (refills only):** Login to the Capital Rx member portal to place an order for available refills.
- **Mail:** Mail your paper prescription to Optum Home Delivery at 6800 W 115th St. Suite 600, Overland Park, KS 66211-9838.

Please note: If you are a new member and received a letter saying Capital Rx will be working with your previous pharmacy to transfer your current prescription(s) to Optum Home Delivery, it is important to still call Optum to ensure all your prescriptions were transferred. If your current prescription is expired, has zero refills remaining, or for controlled substances, your prescriber will need to submit a new prescription.

Save time and stay on track with home delivery and automatic refills.

How does the automatic refill program work?

Log into the Capital Rx member portal to view and enroll all eligible medications. Then, Optum Home Delivery will send your refills when it is time. You will receive reminders before an order is shipped. The pharmacy will bill the preferred payment method saved in your profile. You can adjust what medications are enrolled and the preferred payment method used at any time online.

NEED HELP? CALL CUSTOMER CARE USING THE PHONE NUMBER ON THE BACK OF YOUR ID CARD.

Support with home delivery or questions related to your pharmacy benefit is available 24 hours a day, 7 days a week.

Medical and Prescription Drug Highlight Comparison

Below is an at-a-glance chart that highlights the medical benefits under the Independence Blue Cross medical plans. The chart provides a quick snapshot of the differences in copayment and coinsurance levels when you use in-network providers. This is not intended to be a comprehensive summary, it will only give you basic details about your plans. For more details, please refer to the Summary of Benefits for each plan.

Benefit (only in-network costs are listed here)	**Independence Blue Cross**		
	Personal Choice PPO 10/20/70	**Keystone DPOS C2-F2-01**	**Personal Choice HDHP with HSA**
Deductible Individual / Family	$0 / $0	$0 / $0	$2,000 / $4,000
Health Savings Account Contribution by District	No	No	Contribution depends on your employee type. Full-time Prof/Admin/AT/Confid/Support A, B & C (Aides) = $500 single; $1,000 family *Contribution prorated for mid-year enrollments
Out-of-Pocket Limit Individual / Family	$1,500 / $3,000	$1,500 / $3,000	$8,050 / $16,100
Referrals Required	No	Only for routine radiology, spinal manipulation & OT/PT	No
Outpatient Care			
PCP Office Visits	$25	$25	No charge after deductible
Specialist Office Visits	$40	$40	No charge after deductible
Outpatient Surgery	$75	$75	No charge after deductible
Laboratory/Pathology Services	$0	$0	No charge after deductible
Routine Radiology/Diagnostic	$20	$30	No charge after deductible
Magnetic Resonance Imaging (MRI)	$20	$60	No charge after deductible
OT/PT/Speech	$25 (60 visits/year)	$30 (OT/PT – 30 visits/year; Speech – 20 visits/year)	No charge after deductible (OT/PT – 30 visits/year; Speech – 20 visits/year)
Hospitalization	$75/day; max of 5 copays per admission	$100/day; max of 5 copays per admission	No charge after deductible
Emergency Room	$40	$100	No charge after deductible
Urgent Care Center	$28	$70	No charge after deductible
Routine Eye Exam	No coverage	$40	No coverage, eligible HSA or FSA expense
Prescription Drugs			
Retail (up to 30-day supply)	Generic: $15 Brand: $45 Non-Formulary: $60	Generic: $15 Brand: $45 Non-Formulary: $60	Generic: $15 after deductible Brand: $45 after deductible Non-Formulary: $60 after deductible
Mail Order (up to 90-day supply)	2x retail	2x retail	2x retail

Health Savings Account (HSA) and High Deductible Health Plan (HDHP) – Q&A

The School District of Springfield Township is committed to helping you and your family manage the high costs of health care by providing you with an HSA program that you can use in conjunction with the HDHP. An HSA provides tax-free dollars for qualified out-of-pocket health expenses if you are enrolled in a high deductible health plan. The following are a few important things you should know about:

What is a Health Savings Account?

The HSA is a tax-favored account used in conjunction with a high deductible health plan. The HSA allows you and/or the district to contribute funds on a pretax or tax-deductible basis, which you may use to pay for eligible medical, dental and vision expenses. Eligible expenses are defined by the IRS Publication 502. If you don't use all the money in your account, the balance rolls over to following years. Those dollars continue to earn interest — and continue to be available for medical expenses year after year.

Who is eligible to establish an HSA?

You are eligible to open an HSA provided you have met the following criteria:

- Must be enrolled in an HDHP and not also be covered by another health plan that is not an HDHP
- Not listed as a dependent on another person's tax return
- Not entitled to benefits under Medicare

How is a HDHP/HSA plan different than a traditional health plan?

Health insurance premiums under a HDHP are lower than the cost of traditional health insurance. Therefore, you do not have to pay as much upfront for the cost of benefits if you do not use it. You will have to pay a deductible.

How can an HSA save me money?

The principal balance may be held in a guaranteed fixed interest rate investment option. Interest is tax-free and higher than in many other types of savings accounts.
Also, HSA's have no administrative fees so money grows faster than in an IRA or other savings or investment accounts.

Can I still go to my regular doctor?

Yes. With an HDHP/HSA, you are free to use any doctor and any hospital you choose. With an HSA plan, you will still have an insurance ID card, and you will need to make sure that you present this card anytime you go to the doctor or pharmacy. This will ensure that you always get any network discounts available to you and that your medical provider will be able to file a claim with IBC so any out-of-pocket amounts will be applied to your deductible.

How does it work?

Since an HSA is a tax benefit, you will need to be able to prove that money you spend from your HSA is for eligible medical expenses. If you use an in-network provider, they can file your claim for you. Or, you could simply save the bills and submit them to IBC yourself, either all at once or after you have reached a certain limit in bills. Remember to attach original receipts and any benefits statements along with your claim forms.

Will I have to pay whatever the doctor charges me and how will I be able to obtain a timely reimbursement?

In most cases, doctors are generally encouraged to wait for the insurance company to process your claim before they request payment from their patients. You should also wait for your insurance to process your claim before making any payment to the providers. IBC negotiates a price with its network doctors which is usually much less than what the doctor typically charges, and that savings is passed on to you. If you don't receive a reimbursement within a reasonable time, check with your provider to see if you have a credit balance.

Do I need to choose a primary care physician and obtain a referral to see a specialist?

No. You have the freedom to use any doctor or hospital without being required to choose a primary care physician or receive referrals.

How much can be in the HSA account?

For plan year, 2024-2025, you can save up to the maximum contribution limit of $4,150 for an individual health HSA plan and $8,300 for a family HSA health plan each year through payroll deductions.

If you are married and your spouse has a family HDHP, then both spouses are determined to have family coverage. This is true even if one spouse has a family plan and the other has a self-only plan. Each spouse may have an HSA, and together you may contribute up to the family limit. You may not each contribute up to the family limit.

If you are age 55 and older you may contribute an additional $1,000 to your HSA. This is a "catch up" contribution that may be made each year that you are eligible for a HDHP. Once you enroll in Medicare you may no longer do this.

What does it mean to pay a deductible?

The deductible must be satisfied each year before the insurance company pays on any medical claims.

What happens after my deductible is satisfied?

The plan pays 100% for medical services.

Is the HSA account portable?

Yes. You keep your HSA even if you change jobs, change medical coverage, retire or make other life changes.

Who administers the HSA?

The custodian and administrator of the HSA is WealthCare Saver. Visit their website at www.ibx.com and log into your Blue Cross account.

How Health Care Reform Impacts Your HSA and Maybe Your Taxes

Your medical health plans with the School District of Springfield Township allows you to provide coverage for your eligible dependents until they reach age 26. But, the IRS tax law did not change the definition of a dependent for HSA. A tax-dependent is defined as up to age 19 or, if full-time student, age 24. There can be instances where you can have an adult dependent child covered under your health plan as allowed under the Affordable Care Act (less than age 26), BUT they are not a dependent for tax purposes. If you use the pretax dollars from your HSA to pay for health expenses for your covered dependent (who is not a dependent for tax purposes) you'll pay a penalty plus taxes.

Here is an option you can take to avoid tax issues:

Your covered adult dependent child may open his or her own HSA and contribute up to the allowed individual maximum ($3,850 in 2024).

To do so, call Human Resources and ask what is required. Please be aware that the deposits to the account will be on a post-tax basis and are not handled through any payroll deductions.

You may also continue to save up to the maximum family contribution amount in your own HSA ($8,300 in 2024; if 55 or older an additional $1,000). No penalty will apply as long as you do not use your HSA to cover eligible expenses for a non-tax dependent child.

SDST May Contribute to your HSA!

SDST helps you to fund your HSA, by contributing to individual's accounts, and to families accounts annually. Please see the comparison sheet for details.

How to Get Reimbursed

When you want to be reimbursed for an out-of-pocket health care expense, you can do so easily by signing in to www.ibx.com. Independence Blue Cross and WealthCare Saver will process the request and reimburse you as long as there are sufficient funds in your account. Reimbursements can be sent to you as a check, but a more convenient option is setting up direct deposit with your checking or savings account so the money is automatically sent there.

To submit a mobile reimbursement claim, download the Further mobile app from the Apple Store or Google Play Store Apps and tap "Get Reimbursed."

GOOD TO KNOW: Traveling

Guest Membership & Medical Insurance While Traveling

Keystone DPOS Plan

If you or one of your dependents will be traveling or living outside of the network area, you may apply for a Guest Membership to be able to receive services. You must renew your Guest Membership each year. Contract HR for the form or it is available to you on the Human Resources Google Intranet Site.

Personal Choice PPO Plans

The BlueCard Worldwide program enables PPO members to receive inpatient and outpatient hospital care and physician services when traveling in the US. The BlueCard Worldwide program includes medical assistance services and an expanded network of health care providers throughout the word. For more information contact HR or go to the HR Google Intranet Site.

GOOD TO KNOW: Urgent Care

What is an Urgent Care Center?

A health care facility staffed by board-certified doctors that can provide medically necessary treatment for a sudden illness or injury that requires prompt medical attention but is not life-threatening.

What is a retail health clinic?

A health care facility staffed by certified nurse practitioners that can treat minor, uncomplicated illnesses and injuries.

Does my health plan cover this?

Yes. Simply present your member ID when you arrive. With this benefit you will pay less to visit a participating urgent care center or retail health clinic then you'll pay for an emergency room visit. Locate a participating urgent care center near you, visit ibx.com/findcarenow. Questions? Call 1-800-ASK-BLUE.

Dental Benefit Information

Springfield Township will continue dental benefits through United Concordia for the upcoming plan year. The plan offered is the Advantage Plus Network.

The benefit summary for the Dental Insurance plan through United Concordia is available for you to view on the Human Resources Google Intranet Site. Please note that any deductibles or maximums will accrue on a fiscal/school year (July through June) basis.

Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (PPACA or ACA) requires health plans to provide consumers with information about health plan benefits and coverage in a simple and consistent format called a Summary of Benefits and Coverage (SBC). The purpose of the SBC is to help consumers better understand the coverage they have and allow them to easily compare different coverage options. It summarizes key features of the plan, cost-sharing provisions, and coverage limitations and also provides coverage examples. A Uniform Glossary explaining the most common terms used in health insurance is also available. SBCs are available on the Human Resources Google Intranet Site or you may request a paper copy by contacting Emily Kehr at emily_kehr@sdst.org.

This Open Enrollment newsletter covers only the highlights of SDST's Benefits Programs. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. SDST intends to continue these programs but reserves the right to change or end them at any time. Participation in the programs does not imply a contract of employment.

Health & Wellness Programs through IBC

There are additional benefits available through your medical plans that are designed to encourage healthy behaviors. Additionally, discounts are available on products and services to help improve your health and save you money. You must register to take advantage of these benefits by calling **800-ASK-BLUE** or visiting the website at www.ibx.com and click on Health and Wellness.

Healthy Lifestyles℠ Solutions Program

Enroll in Weight Watchers®, Weight Watchers® Online, or an approved weight management program at any network hospital. The Healthy Lifestyles℠ Solutions Weight Management Program will reimburse you up to $150 for the cost of an approved weight management program. To get started:

- Sign up for an approved weight management program
- Attend the approved program
- Submit documentation and request your reimbursement

Log onto www.ibx.com/reimbursements and request your reimbursement by submitting proof of participation and payment. Once all of your documentation is submitted, you can request your reimbursement to be paid by direct deposit or American Express rewards gift card.

Fitness Program Reimbursement

You can get up to $150 back when you join a full-service fitness center. Exercise regularly (120 times a year) at an approved fitness center, record your workouts, and submit your documentation for reimbursement. Reimbursements can be obtained by direct deposit or an American Express rewards gift card.

Other IBC Health & Wellness Resources

IBC offers access to a variety of products and services to help you live a healthy lifestyle and manage your everyday life. You and your family members can obtain information on the following programs:

- **Stress Management** – Receive a stress-relief guide.
- **Baby BluePrints** – A maternity program designed to help you be healthy, confident, and comfortable throughout your pregnancy.
- **24/7 Nurse Line** – Members have access to speak with a registered nurse 24 hours, 7 days a week.
- **WebMD** – Helps members better understand their symptoms and what to do about them.
- **Personal Health Profile** – Health risk assessments members complete through the member portal that results in a health analysis and personalized action plan.
- **Educational Videos** – View short educational videos on any one of thousands of health topics.
- **Connections Health Management Programs** – Provides members with an accurate, confidential and personalized action plan to support physicians' relationship with their patients and enhance their ability to provide evidence-based care.
- **Nutrition Counseling** – Members receive up to six visits a year with a registered dietician to learn how to eat a healthier diet.
- **And much more**

Tobacco Cessation Program

No matter who you are, you can find a program that will give you the type of support and encouragement you need to kick the habit. Receive $150 back when you complete your choice of proven tobacco cessation programs. Eligible programs include those that focus on behavior modification and provide frequent and regular support such as weekly meetings or telephone-based sessions.

You can work with your health care provider to determine which method is best for you. You may meet one-on-one with a provider, or choose a program that offers group support. Some programs can even help you manage stress, avoid weight gain, and overcome barriers to quitting. You can also choose a program offered by a network hospital in your area. Search for a network hospital in your area at www.ibxpress.com or contact our Health Resource Center at 800-ASK-BLUE for more information.

The following are not reimbursable:

- Copays, coinsurance and deductibles
- Hypnosis
- Acupuncture
- Dietary supplements; injections
- Electronic cigarettes

Blue365 Your resource for living healthier.®

As an IBC member, you are automatically eligible for Blue365. 365 days a year, Blue365 is available to help you make important decisions about your health and wellness. Simply log on to Blue365 from the ibxpress.com website and you will receive access to discounts, nutrition and weight management programs, laser vision correction, parent and senior care, health travel and more.

Visit your member website at www.ibxpress.com to:

- Find a provider
- View claims
- Review your coverage details
- View health & wellness program

Telemedicine

24 hours a day, 7 days a week on demand access to affordable quality healthcare. Anytime, anywhere.

With Telemedicine through Teladoc, you can visit with a doctor from your home, office, or on the go. TELADOC's network of Board-Certified doctors and licensed therapists is available 24/7 by phone or secure video to assist with non-emergency medical conditions.

Download the Teladoc Mobile App from the Apple Store or Google Play. Visit teladochealth.com or call 1-800-835-2362.

When should I use Teladoc?

- Instead of going to the ER or an urgent care center for a non-emergency issue
- During or after normal business hours, nights, weekends and even holidays
- If your primary care physician is not available
- To request prescription refills when appropriate. See prescription policy*
- If traveling and in need of medical care

What can be treated?

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and Flu
- Constipation
- Diarrhea
- Ear Infection
- Fever
- Headache
- Insect Bite
- Joint Aches
- Nausea
- Rashes
- Sinus Infection
- Sore Throat
- UTI
- And more!

Are my children eligible?

Yes. Teladoc has pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors.

There is a caregiving option, which allows a babysitter to schedule a visit on your behalf if your child gets sick while in their care.

Who are Teladoc doctors?

Teladoc has one of the largest network of doctors for telehealth services with board certified doctors who are available by phone, web, or the Teladoc app.

Interpreters who know your language including

How much does it cost?

Members will pay their primary care copay per consult for the Keystone & Personal Choice plans. If enrolled in the HDHP plan, members will pay the $40 cost until their deductible is met.

Contact Teladoc for affordable care anytime, anywhere.

- Download the Teladoc app
- 1-800-835-2362
- Visit teladochealth.com

* Prescriptions are issued only when clinically appropriate and will be prescribed for a short-term duration. No controlled substances can be prescribed, and the availability can be restricted by law.

Life Insurance

For most people, maintaining their lifestyle depends on an important source of income – regular paychecks. If you should die, your family's lifestyle could suffer. SDST recognizes that life insurance provides critical financial protection. Please view your contract for the specific amount of coverage you are provided for by the District at no cost to the employee.

Disability Insurance (STD or LTD)

The purpose of this plan is to provide you with income if you are not able to work due to a non-work-related illness or injury. Support and Confidential Staff are provided Short Term Disability (STD) insurance per their contract/agreement at no cost to the employee. Administration is provided Long Term Disability (LTD) insurance per their agreement at no cost to the employee. Please view your contract/agreement for the specific insurance provided or contact the HR office for more information.

Workers Compensation Insurance

Workers Compensation Insurance is provided to all district employees if you are injured on the job. Please see the notice with insurance and the posted panel of physicians on the HR Google Intranet website.

403b/457 Retirement Plans

All district employees are eligible to open a 403b/457 retirement plan with one of the approved vendors. Please view a detailed explanation and the list of vendors on the HR Google Intranet website.

Public School Employees' Retirement System (PSERS)

Go to https://www.psers.pa.gov/Pages/default.aspx for more information about the pension plans.

Employee Assistance Program (EAP)

Life may present you with unexpected challenges and the district would like to be able to offer some assistance for you during difficult times. All information discussed will remain confidential. 1-800-628-4844 or www.guidanceresources.com. Web ID= PFGEAP. Company ID= School. For more information view the HR Google Intranet Page.

Update Your Beneficiary

Open Enrollment is a good time to review your beneficiaries for your life insurance and pension. Please update your beneficiary through open enrollment or contact HR.

Imputed Income

If your Basic Life insurance exceeds $50,000, the Federal government taxes the "value" of the coverage (i.e., the cost to provide the benefit) above $50,000. This is called imputed income. The imputed income is not the amount of your coverage above $50,000 but the premium value of your coverage above $50,000, as determined by the IRS. This taxable amount appears on your W-2 statement, generally as "other income."

Voluntary Benefits

The plan options available to you are designed to help supplement your medical plan. The benefits you receive under these plans may be used for out-of-pocket medical or non-medical expenses associate with a covered accident, critical illness or hospital stay. Please take the time to review the plan information to determine which insurance options may be the best fit for you and your family.

Trustmark Short-Term Disability	Select from two elimination periods: 7/7 or 14/14 Select from two benefit periods: 3 months or 6 months Protect up to 60% of your base earning $100 claims-free return, every two years
Trustmark Group Hospital Indemnity	Pays cash directly to Employee, over and above any other coverage HSA Compatible Pays cash benefits for Hospital Admission, Hospital Confinement, Hospital Intensive Care
Chubb 24-Hour Group Accident Plan	Pays cash directly to Employee, over and above any other coverage. Pays cash benefits for injuries such as slip and fall, doctor visits, chiropractic, fractures, dislocations, surgeries, hospital stays, therapies, plus other benefits. $60 wellness benefit paid once per year per insured
Chubb Group Critical Illness Plan	Pays cash directly to Employee, over and above any other coverage. Pays lump sum from $10,000 - $30,000 on a guaranteed issue basis for the diagnosis of a covered condition. Does not require hospitalization or any treatment for benefit to be paid, only qualifying diagnosis. Covered conditions include: Heart Attack, Stroke, Cancer, End Stage Renal Failure, Coma, Major Organ Failure, Alzheimer's, Parkinson's, plus others $50 wellness benefit paid once per year per insured
Colonial Life Term Insurance	Three plan options to choose from: 10 year / 20 year / 30 year Same benefit payout for the duration of the policy Guaranteed premiums that do not increase during the selected term Coverage up to $150,000

Flexible Spending Accounts (FSAs) with Ameriflex

A Flexible Spending Account (FSA) is an easy, convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of pretax dollars to cover certain out-of-pocket expenses as they occur throughout the year. At SDST we offer two types of Flexible Spending Accounts: Health Care FSA and Dependent Care FSA. IRS rules allow you to contribute to your Flexible Spending Accounts through pretax payroll deductions. This means the money is deposited to your account before any deductions for income tax, Social Security or state withholding taxes are taken from your paycheck.

Health Care Flexible Spending Accounts

Health Care Flexible Spending Accounts reimburse you for eligible health care expenses that are not covered by your health benefits plan, such as copayments, coinsurance, deductibles or certain vision, hearing or orthodontic care costs. You can submit claims for yourself, your spouse and other covered family members.

At the start of the plan year, you choose how much you want to set aside with each paycheck — subject to an annual maximum. 2024= $3200.00. You then withdraw funds from your account as needed throughout the year to reimburse yourself for the eligible health care expenses you have paid out-of-pocket (i.e., anything not covered by insurance). The entire elected amount is available to you from the first day of the plan year.

If you enroll in the HDHP plan with a Health Savings Account (HSA) you will only be eligible to enroll in a Limited Flexible Spending Account for dental and vision claims.

Dependent Care Flexible Spending Accounts

Dependent Care Flexible Spending Accounts reimburse you for non-medical day care expenses for **children under age 13** or for disabled dependents of any age (a dependent that is not able to care for himself or herself and relies on you for sole financial support). Dependent day care expenses are reimbursable as long as the provider is not your spouse, another dependent or child under age 19. To be eligible to participate, both you and your spouse must be working or you are a single parent. At the start of the plan year, you choose how much you want to set aside with each paycheck – $2,500 maximum if you are married and filing a separate income tax return or $5,000 maximum if you are single or married filing a joint income tax return. You then withdraw funds from your account (up to the amount of contributions available in your account) as needed throughout the plan year to reimburse yourself for the dependent day care expenses that you have already paid.

Save Your Receipts

You may be required to provide documentation.

Health Care FSA Ineligible Expenses

- Babysitting, childcare and nursing services for a normal, healthy baby
- Controlled substances or illegal drugs
- Cosmetic surgery
- Dancing lessons
- Diapers or diaper service
- Electrolysis or hair removal
- Funeral expenses
- Future medical care (except advance payments for lifetime care, or long-term care)
- Hair transplant
- Health coverage tax credit
- Household help
- Illegal operations or treatments
- Insurance premiums (with a few exceptions)
- Maternity clothes
- Medication from other countries
- Nonprescription drugs and medicine, except insulin (over-the-counter medicine is eligible for reimbursement with a written prescription)
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition
- Personal use items (e.g., toothbrush, toothpaste, dental floss)
- Swimming lessons
- Teeth whitening
- Veterinary fees
- Weight-loss program (unless for a specific disease diagnosed by a physician)

Please note that this list is not all-inclusive, and is subject to change.

You must re-enroll each year to continue in the program.

Ameriflex Offers Instant Access to FSA Funds

Accessing your FSA account funds is easy with the Ameriflex Debit Card, which you may use at participating doctors, hospitals, dentists, and pharmacies that accept debit cards. Just present your card at the time of payment when you have qualified expenses. The amount of your purchase will be deducted from your Spending Account, up to the maximum amount you have elected for the year. Since this is an IRS approved program, make sure you keep all your receipts for purchases you make with your wage works debit card for eligible health care and transit expenses.

To learn more about flexible spending accounts, visit the district HR Google Intranet Page.

Use It or Lose It!

As you think about your FSA for this upcoming plan year, be sure to carefully estimate your expenses, as well as the amount you want to contribute to your account. As you do so, remember that as a result of the national Health Care Reform, you may no longer use the Health Care FSA to pay for certain over-the-counter drugs and medicine without a doctor's prescription or letter of medical necessity. The goal in estimating carefully is to use whatever you set aside so you do not lose it, due to the Internal Revenue Service's "use it or lose it" rule. This rule means if you do not spend the full amount of money in your FSA by the end of the plan year, you must forfeit whatever funds remain above $640.00.

Example of How Much You Can Save

Let's say you earned $26,000 and you contributed $2,000 to your Health Care Account:

	With A Health Care Flexible Spending Account	Without A Health Care Flexible Spending Account
Annual Base Salary	$26,000	$26,000
Health Care Flexible Spending Account Contribution (Pre-tax Dollars)	$2,000	$0
Taxable Income	$24,000	$26,000
Federal Income Tax **Social Security Tax**	$2,475 $1,836	$2,774 $1,989
Net Income	$19,689	$21,237
Unreimbursed Health Care Expenses	$0	$2,000
Your Spendable Income	$19,689	$19,689

You increase your spendable income by $452 simply by participating in the Health Care FSA.

Please remember: These projections are only estimates. The assumptions used in these calculations may not apply to you. Do not consider them to be tax advice. Always ask your tax advisor for the most appropriate tax advice for your specific situation.

Do you have a question about your coverage?

Contact the appropriate vendor directly for questions regarding benefits, claims process, choosing a doctor, ID cards and copayments and deductibles.

Contact Information			
Benefit	**Provider**	**Website**	**Phone Number**
Medical	Independence Blue Cross	www.ibx.com	Call the number on the back of your ID Card
Prescription Drug Coverage	CapitalRx	www.cap-rx.com	833-599-1001
Dental	United Concordia	www.unitedconcordia.com	800-332-0366
Flexible Spending Accounts	Ameriflex	https://participant.myameriflex.com/#/login	610-291-6528
Employee Assistance	Compsych	www.guidanceresources.com	800-628-4844
Retirement Plan	PSERS	https://www.psers.pa.gov/Pages/default.aspx	215-443-3495
Workers Compensation	School Districts Insurance Consortium (SDIC)	http://sdicwc.org	800-445-6965
Voluntary Insurance – Short-Term Disability & Hospital Plan	Trustmark	https://www.trustmarkbenefits.com/voluntary-benefits	800-918-8877
Voluntary Insurance – Accident/Injury & Critical Illness	Chubb	www.chubb.com/WorkplaceBenefitsClaims	833-542-2013
Voluntary Insurance – Life	Colonial Life	www.coloniallife.com	800-325-4368

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 January 31, 2024. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California – Medicaid

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

Colorado – Health First Colorado (Colorado's Medical Program) & Child Health Plan Plus (CHP+)

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

Kentucky – 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

Louisiana – 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)

Maine – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268

Georgia – Medicaid

A 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

Indiana – 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

Iowa – Medicaid and CHIP (Hawki)

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

Kansas – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

North Dakota – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

Massachusetts – Medicaid

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

Minnesota – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000 Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

New Jersey – Medicaid and CHIP

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

Vermont – Medicaid

Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

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

Washington – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

Utah – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

West Virginia – Medicaid and CHIP

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)

Wisconsin – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

Wyoming – Medicaid

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 January 1, 2024, or for more information on

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 and Medicaid Services
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565

Important Regulations

Patient Protection – Designation of Primary Care Provider

Independence Blue Cross's HMO and DPOS plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Independence Blue Cross will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit the Independence Blue Cross website at www.ibx.com. For children, you may designate a pediatrician as the primary care provider.

Patient Protection – Patient Access to Obstetrical and Gynecological Care

You do not need prior authorization from Independence Blue Cross or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Independence Blue Cross at 800-275-2583.

Women's Health and Cancer Rights Act

On October 21, 1998, the Women's Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. As the Act requires, we have included this notification to inform you about the law's provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for: 1. Reconstruction of the breast on which the mastectomy has been performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3. Prostheses; 4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Health Insurance Portability and Accountability Act (HIPAA) – State Children's Health Insurance Program (SCHIP)

Loss of other coverage: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of Medicaid or SCHIP coverage: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New dependent: If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption,you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or SCHIP premium assistance: If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Coverage

CHIP is short for the Children's Health Insurance Program — a program to provide health insurance to all uninsured children and who are not eligible for or enrolled in Medical Assistance. CHIPRA is the reauthorization act of CHIP which was signed into law in February 2009. Under CHIPRA, a state CHIP program may elect to offer premium assistance to subsidize employer-provided coverage for eligible low-income children and families. All employers are required to provide employees notification regarding CHIPRA. Please see attached notice.

Medicare Part D Creditable Coverage/ Non-Creditable Coverage Notice

The Centers for Medicare and Medicaid (CMS) requires employers to notify their Medicare Part D-eligible individuals about their creditable coverage status prior to the start of the annual Medicare Part D election period that begins on October 15 of each year. Please see attached notice.

Important Notice from the School District of Springfield Township About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CapitalRx 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:

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.

School District of Springfield Township has determined that the prescription drug coverage offered by CapitalRx 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 15 to December 7. 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 School District of Springfield Township coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current School District of Springfield Township coverage, be aware that you and your dependents will be able to get this coverage back.

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 the School District of Springfield Township 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 November 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 The Company changes. You also may request a copy of this notice at any time.

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

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

For More Information About Medicare Prescription Drug Coverage:

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

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

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

Date:	May 1, 2024
Name of Entity/Sender:	School District of Springfield Township
Contact:	Emily Kehr, Director of HR 215-233-6000