



Brian Metcalf / Superintendent of Schools

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

WHO YOU CAN COVER UNDER THE MEDICAL PLAN

- Yourself;
- Your Spouse;
- Your eligible children up to age 26 or through the end of the year in which the individual turns age 26

HIPAA SPECIAL ENROLLMENT PERIODS

Loss of Other Coverage

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance 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 to the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing to the other coverage).

New Dependent

If you gain a new dependent as the result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

AUTOMATIC ENROLLMENT

If you are a full-time employee, health care reform law may require your employer to automatically enroll you for health care coverage. You will be notified of your enrollment and will have the right to opt-out of coverage by following instructions your employer will provide to you.

CHILDREN'S HEALTH INSURANCE PROGRAM AND MEDICAID ELIGIBILITY CHANGES

If you or your dependents are eligible for medical coverage in this Plan but are not enrolled, you have 60 days to enroll in the Plan in the following two circumstances:

- If you or your eligible dependents' Medicaid coverage or coverage under the state Children's Health Insurance Program (CHIP) is terminated due to loss of eligibility; or
- If you or your dependents become eligible for a premium assistance program in the state in which you reside.

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides group health benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema (swelling caused by the removal of lymph nodes). 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.

NEWBORNS AND MOTHERS HEALTH PROTECTION NOTICE

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Health Plan will not require a provider to obtain authorization from the Health Plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

NOTICE OF ELIGIBILITY FOR HEALTH PLAN RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect continuation coverage under USERRA.

PATIENT PROTECTION NOTICES

If the Plan provides for or requires 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to 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 the Plan Administrator.

If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room.

Your plan covers both in-network and out-of-network emergency services. Your out-of-pocket costs are the same, but you may pay more for out-of-network care in other ways. For example, an out-of-network provider is allowed to bill you for some things that in-network providers can't bill you for.

W-2 REPORTING

The health care reform law requires some employers to report the cost of employer sponsored group health coverage. You may see this reported in Box 12 of your W-2 form. This is an employer reporting requirement only and it won't have an impact on your taxable income or require you to report it on your personal income taxes.

HEALTH INSURANCE EXCHANGE

Beginning in 2014, state/federal-run programs called "health insurance exchanges" will allow individuals and qualified small employers to comparison-shop for health insurance online. Plans in the exchange will have standard levels of benefits – for example, a "gold" plan will have certain features and a "silver" plan will have certain features. Subsidies will be available to low-income people and small businesses that buy insurance through an exchange.

HIPAA NOTICE OF PRIVACY PRACTICES

Your employer is committed to maintaining the privacy of protected health information for participants in the Plan. This is a reminder that in compliance with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) a Notice of Privacy Practices is available to employees. This notice of Privacy Practices explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy or for further information regarding the issues covered by this Notice of Privacy Practices, please contact the Plan Administrator.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to help you maintain your health coverage when you need to change jobs. If you lose coverage under the Plan, the Plan will provide you with a certificate that shows how long you had coverage under the Plan. This is your "creditable coverage." Using this certificate of creditable coverage, you will be able to reduce or eliminate any pre-existing condition exclusion imposed by a new employer plan or group insurance policy. You will automatically receive a certificate:

- When you become a qualified beneficiary entitled to elect COBRA coverage.
- When you lose medical coverage, even though you are not entitled to elect COBRA coverage.
- When your COBRA continuation coverage ends.

You may also request a certificate at any time or within 24 months after your medical coverage ends.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

You can examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

You can obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN ADMINISTRATOR CONTACT INFORMATION

For more information about any of the notices contained herein, or any of your rights under the Plan, please contact the Plan Administrator at:

***Grand Ledge Public Schools
Business Office
220 Lamson Street
Grand Ledge, MI 48837
(517) 925-5423***