

Open Enrollment is November 9-November 23, 2020

Benefit Enrollment Guide
Wyandotte Public Schools

Wyandotte Public Schools
639 Oak St
Wyandotte, MI 48192

Administrative Assistant Employees

WELCOME

Welcome to the Wyandotte Public Schools (WPS) 2021 Benefits Open Enrollment! The District continues to be committed to providing all eligible employees with a comprehensive and competitive benefit package. We continue to offer benefit plans and tools that can help you and your family improve your physical, financial and personal health. This total health approach to benefits provides you with many resources to help you in all aspects of life, and through all of life's stages.

This year we are pleased to announce that we will continue to offer the same plan options to you. There has been an increase in your employee cost share due to PA 152, please refer to page five for details. In addition to your medical plan election, you will have the option to participate in the **saving account options** as follows:

- **Health Savings Account (HSA) - for those who enroll in the Simply Blue High Deductible BCBSM Health Plan**
- **Flexible Spending Account (FSA) - for those who enroll in one of the Community Blue PPO plans, or for those who opt out of our plan (cash in lieu participants)**
- **Dependent Care Account (available to all benefit eligible employees)**

The **annual benefits enrollment** for the plan year that **begins on January 1, 2021**, will be held **November 9-23, 2020**.

We take great pride in the benefit programs that we have been able to offer to our employees through the years. Please carefully review this benefits guide for important and valuable information regarding our benefits program.

Wyandotte Public Schools

Medical/Prescription Plans

The following pages provides you with a side by side comparison of your benefit options to assist you in making your decision. It is intended as an easy-to-read summary and provides a general overview of your benefits. The below is not a contract, additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay.

PLEASE REFER TO YOUR BCBSM BENEFIT SUMMARY FOR ADDITIONAL INFORMATION INCLUDING OUT-OF-NETWORK BENEFITS.

	Community Blue PPO BCBS 100/80% with No deductible	Community Blue PPO BCBS 100/80% with $1,000/$2,000 deductible	Simply Blue PPO HSA $1.400/$2,800 Plan
	In-Network	In-Network	In-Network
Deductible per calendar year			
Individual Family (two or more)	None None	$1,000 $2,000	$1.400 $2,800*
Copays			
Copays	$10 copay for office visits and office consultations $50 copay for emergency room visits	$10 copay for office visits and office consultations $50 copay for emergency room visits	All services are subject to the deductible. See "Prescription Drugs" section for Rx copays
Dollar Maximum (per HCR)			
Annual out-of-pocket maximums—applies to deductible, copays and coinsurance amounts for all covered services—including prescription drug copays and coinsurance amounts, if applicable.	$600 for one member, $1,200 for two or more members each calendar year	$3,500 for one member $7,000 for two or more members each calendar year	$2,250 for one person contract or $4,500 for two or more members each calendar year

*The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.



MEDICAL/PRESCRIPTION PLANS (CONTINUED)

Blue Cross Blue Shield Blue Care Network of Michigan

	Community Blue PPO BCBS 100/80% with No deductible	Community Blue PPO BCBS 100/80% with $1,000/$2,000 deductible	Simply Blue PPO HSA $1.400/$2,800 Plan
	In-Network	In-Network	In-Network
PREVENTIVE CARE (age and maximum number of services may apply) - please refer to the BCBSM website for additional information on these services as well as a listing of all of the covered preventive services.			
Health Maintenance Exam	Covered 100%	Covered 100%	Covered 100%
Annual Gynecological Exam	Covered 100%	Covered 100%	Covered 100%
Pap Smear Screening laboratory & pathology services	Covered 100%	Covered 100%	Covered 100%
Mammography Screening	Covered 100%	Covered 100%	Covered 100%
Well-baby and Child Care	Covered 100%	Covered 100%	Covered 100%
Immunizations	Covered 100%	Covered 100%	Covered 100%
PHYSICIAN OFFICE SERVICES			
Office Visit (Illness/Injury Related) including consultations and online visits	$10 copay	$10 copay	100% after in network deductible
EMERGENCY MEDICAL CARE			
Ambulance Services (medically necessary)	100% after in network deductible	100% after in network deductible	100% after in network deductible
Hospital Emergency room	$50 copay (Waived if admitted or for an accidental injury)	$50 copay (Waived if admitted or for an accidental injury)	100% after in network deductible
Urgent Care Center	$10 copay	$10 copay	100% after in network deductible
DIAGNOSTIC SERVICES			
Laboratory and Pathology Services	100% after in network deductible	100% after in network deductible	100% after in network deductible
Diagnostic Tests and X-rays	100% after in network deductible	100% after in network deductible	100% after in network deductible
Therapeutic Radiology	100% after in network deductible	100% after in network deductible	100% after in network deductible
MATERNITY SERVICES PROVIDED BY A PHYSICIAN OR CERTIFIED NURSE MIDWIFE			
Pre-Natal and Post-Natal Care	Covered at 100%	Covered at 100%	Covered at 100%
Delivery and Nursery Care	100% after in network deductible	100% after in network deductible	100% after in network deductible
HOSPITAL CARE			
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services & Supplies	100% after in network deductible	100% after in network deductible	100% after in network deductible

MEDICAL/PRESCRIPTION PLANS (CONTINUED)

Blue Cross Blue Shield Blue Care Network of Michigan

	Community Blue PPO BCBS 100/80% with No deductible	Community Blue PPO BCBS 100/80% with $1,000/$2,000 deductible	Simply Blue PPO HSA $1.400/$2,800 Plan
	In-Network	In-Network	In-Network
ALTERNATIVES TO HOSPITAL CARE			
Skilled Nursing Care	Covered at 100% after deductible up to 120 days per calendar year	Covered at 100% after deductible up to 120 days per calendar year	Covered at 100% after deductible, limited to 90 day maximum
Hospice Care	Covered at 100% (visit limits apply)	Covered at 100% (visit limits apply)	Covered at 100% after deductible (visit limits apply)
Home Health Care	100% after in network deductible	100% after in network deductible	100% after in network deductible
SURGICAL SERVICES			
Surgery—includes all related surgical services	100% after in network deductible	100% after in network deductible	100% after in network deductible
Voluntary Sterilization for Males	100% after in network deductible	100% after in network deductible	100% after in network deductible
HUMAN ORGAN TRANSPLANTS			
Specified Organ Transplants—designated facilities only	Covered at 100%	Covered at 100%	100% after in network deductible
Bone Marrow—specific criteria applies	100% after in network deductible	100% after in network deductible	100% after in network deductible
Kidney, Cornea and Skin	100% after in network deductible	100% after in network deductible	100% after in network deductible
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT			
Inpatient Mental Health Care & Substance Abuse Treatment	100% after in network deductible	100% after in network deductible	100% after in network deductible
Outpatient Mental Health Care	100% after in network deductible	100% after in network deductible	100% after in network deductible
Outpatient Substance Abuse Treatment	100% after in network deductible	100% after in network deductible	100% after in network deductible
OTHER SERVICES			
Allergy Testing	Covered at 100%	100% after in network deductible	100% after in network deductible
Chiropractic Spinal Manipulation (visit limitations may apply)	Covered at 100% 24 visits max	$10 copay per visit 24 visit max	Covered at 100% after deductible, up to combined 12 visits
Outpatient Physical, Speech and Occupational Therapy (visit limitations may apply)	100% after deductible, up to 60 visits per cal. yr.	100% after deductible, up to 60 visits per cal. yr.	Covered at 100% after deductible, up to 30 visits per cal. yr.
Durable Medical Equipment	100% after in network deductible	100% after in network deductible	100% after in network deductible
Prosthetic and Orthotic Appliance	100% after in network deductible	100% after in network deductible	100% after in network deductible
PRESCRIPTION DRUGS* NOTE: THE SIMPLY BLUE PLAN REQUIRE THAT YOU MEET YOUR FULL CALENDAR YEAR DEDUCIBLE BEFORE THE RX COPAYS APPLY. THIS MEANS THAT YOU WILL BE RESPONSIBLE TO PAY THE FULL COST OF ALL MEDICATIONS UNTIL YOU SATISFY YOUR DEDUCTIBLE.			
Retail Generic	$5 Covered through CVS/Caremark	$10	After deductible $5 copay up to $1,000/$2,000 copay max.
Retail Brand	$10 Covered through CVS/Caremark	$40	After deductible $25 formulary brand and $50 non-formulary brand up to $1,000/$2,000 copay max.

*Mail order prescription drugs are covered at 2X the applicable copays noted above.

EMPLOYEE CONTRIBUTIONS

Premium Conversion



To help minimize your employee contribution for your medical plan, WPS will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your employee contribution for the medical coverage on a pre-tax (before tax) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post-tax (after tax) basis. Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket.

Healthcare Premiums - January 1, 2021 to December 31, 2021

The following chart provides employees with the contributions for the plans offered this year. Figures listed are subject to change if there is a change to the cost of insurance. Amounts paid by WPS are limited by PA 152; employees are responsible for any amounts above limits set by PA 152. Employee contribution rates effective January 1 , 2021 are:

Tiers	Plan Options	Monthly Cost
Single	**CB PPO 100/80% with No deductible**	$297.43
2 Person	**CB PPO 100/80% with No deductible**	$894.67
Family	**CB PPO 100/80% with No deductible**	$1,051.84
Single	**CB PPO 100/80% with $1,000/$2,000 deductible**	$85.93
2 Person	**CB PPO 100/80% with $1,000/$2,000 deductible**	$387.42
Family	**CB PPO 100/80% with $1,000/$2,000 deductible**	$417.86
Single	**Simply Blue PPO HSA $1.400/$2,800 Plan**	$0.00
2 Person	**Simply Blue PPO HSA $1.400/$2,800 Plan**	$0.00
Family	**Simply Blue PPO HSA $1.400/$2,800 Plan**	$0.00

Opt-Out (cash in lieu)

Employees who opt out of medical may be eligible for a cash in lieu benefit. Please refer to your collective bargaining agreement for details.



Other District Benefits

Please note, there is no change to your life and disability benefits provided by the District. For additional information on these benefits, please contact Diane Fisher, Benefits Coordinator, at **FisherD@wy.k12.mi.us** or at **734-759-6006**.

BCBSM Online Access

Managing your health plan online has never been easier.

With the new member site, you now have access to:

One site. One stop.

- Personal snapshot of your plan:
  Check out easy-to-understand graphics that provide a quick snapshot of your deductibles, coinsurance and claims.
- Single user ID for life:
  Once registered, your personal ID stays with you, even if you switch plans, change jobs or retire.

The power to compare.

- Powerful search capabilities:
  We've added more search and filtering functionality, so you can find the doctors and hospitals that you prefer.
- Extensive cost and quality comparisons:
  Evaluate up to six doctors or hospitals side-by-side, comparing quality and costs for hundreds of services across the country.

  Cost *information for PPO members only*
- Helpful patient reviews:
  You can read reviews about specific doctors from other patients and even leave one of your own.

On the go. Good to go.

- 24/7 access:
  With your mobile device, you have another way to access important plan information when you need it most, 24 hours a day, seven days a week.
- On-the-spot doctor and hospital search:
  Make decisions on where to go, when you're on the go.
- Virtual ID card:
  If you forgot to bring your ID card to your doctor appointment, there's no need to worry. You can now access your virtual ID card right from your mobile device.

Register Now – we've made it easy for you:

- **Visit bcbsm.com**
- **Click on LOGIN in the upper right corner**
- **In the LOGIN box, click on Register Now**

You'll need your Blues ID card and just a couple minutes.



BCBSM Online Visits

Connect virtually to a doctor 24/7 365 from your smart phone or tablet



Health Savings Account Overview



A **Health Savings Account (HSA)** is a cross between a flexible spending account (FSA), an IRA, and a 401(k)/403(b). **Only those who enroll in the BCBSM Simply Blue plan have the option to participate in the HSA, if eligible.** You can access your HSA to pay for eligible expenses. In addition, your account has the ability to grow, year-to-year, tax deferred. HealthEquity will be the HSA third party trustee. The HSA account is your property and responsibility. Like a 401(k)/403(b), it is your money and stays with you.

Eligibility

You must meet certain other requirements in order to participate in the HSA Contribution feature. To be eligible, you must:

(a) Be covered by the Simply Blue High Deductible Health Plans;

(b) Not be claimed as another person's tax dependent;

(c) Not be covered by Medicare; and

(d) Not have any health coverage other than coverage under a High Deductible Health Plan. Other coverage that will disqualify you from being eligible for the HSA Contribution Feature includes, but not limited to, coverage under your spouse's health plan if his/hers is not considered a HDHP plan under IRS guidelines. Coverage under your spouse's medical expense reimbursement plan or flexible spending account, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

HSA Employer Funding

For the 2021 plan year, WPS will partially fund each employee's HSA account. Please note that this applies to benefit eligible employees only. Below is an overview of funding.

WPS 2021 Total HSA Funding	HSA Funding Date
$330 Single $660 Couple or Family	**First week of January of 2021**

HSA Employee Funding (Optional)

In additional to the Health Savings Account (HSA) funding you may receive from WPS, you will have the option to fund your account with pre-tax dollars.

The Statutory Maximum HSA Contribution for **2021** calendar year is $3,600 for a single and $7,200 for a family. These limits included both your and WPS's contributions. If you are age 55 or older, you can make an additional catch-up contribution amount of $1,000 in 2021. The HSA cannot receive contributions after you have enrolled in Medicare.

You have the ability to adjust your HSA pre-tax election monthly.

Using Your HSA

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

Keeping track of your account balance is easy. You can review your account information 24/7 by logging onto the www.BCBSM.com website or by calling HealthEquity at 877-284-9840.

Your HSA money is tax-free as long as it is used to pay for qualified medical expenses. If you use the money for any other reason, you will be required to pay income tax and a 20% tax penalty on that amount (you will not pay a penalty if you are disabled or age 65 or older).

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

HEALTH SAVINGS ACCOUNT (CONTINUED)

Frequently Asked Questions



What is my HSA?

Your HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) that is authorized to be the trustee of HSAs. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you.

You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your employer has no control of; or responsibility for the investment of your HSA.

What are the limits on the amount of contributions?



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

You are allowed to make or receive an additional—catch up contribution for the year in which you will attain age 55 before the end of the year and for any year thereafter while you remain eligible. The catch-up contribution is currently $1,000 per year.

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

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

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

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

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

If you are married and both you and your spouse have coverage under a Qualifying High Deductible Health Plan and you both have health savings accounts, the limit is divided equally between you (unless you agree to a different allocation).

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

HEALTH SAVINGS ACCOUNT (CONTINUED)

What happens if my contributions exceed the contribution limit?

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

What are the tax consequences of the HSA Contribution Feature?

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

What are the rules regarding distributions from my HSA?

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

When does my participation end?

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

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

Can the contributions made to my HSA be forfeited?

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

What are the reporting requirements?



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

The intent of this analysis 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 or tax advice.

ADN Dental Coverage

PO Box 610
Southfield, MI 48037
248-901-3705

WYANDOTTE PUBLIC SCHOOLS Dental Benefits Plan **Group # 10002**
Administrators, Secretaries

The Plan-at-a-Glance **PPO Networks: ADN Dental Network, Michigan Dental Plan, DenteMax**

Maximum Benefits	**Plan Year January 1st through December 31st**
Annual Maximum	$1200.00 per eligible individual for covered class I, II and III services.
Lifetime Ortho Maximum	$ 500.00 per eligible individual for covered class IV services

Class I Preventive Services – 80%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
Sealants	Once per tooth every 36 months to age 16
Space Maintainers	Once per area per lifetime, to age 16

Class II Restorative Services – 80%	
Composite and Amalgam fillings**	Once per tooth surface per 24 months
Inlays, Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Periodontal Maintenance	Four times per plan year following treatment, includes prophylaxis
Occlusal Guard	By report, once per lifetime
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	With covered Oral Surgery or Medically necessary
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch

Class III Major Services – 80%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months

Class IV Orthodontic Services – 50%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19

Not Covered

Implants and Related Restorations
TMJ/TMD Treatment
Cosmetic Treatment

Deductible –None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

FLEXIBLE SPENDING ACCOUNTS (FSA)

WPS will continue to offer the Health Care and Dependent Care Flexible Spending Accounts (FSA's). The Health Care and Dependent Care Flexible Spending Accounts allow you to set aside pre-tax dollars from your paycheck to pay for eligible health care and/or dependent care expenses.

Effective January 1st the FSA plan will continue to be offered through Employee Benefit Concepts.
Employees who enroll in the BCBSM Simply Blue Plan are NOT eligible for a Health Care FSA. The FSA plan year will be 1/1/20 through 12/31/20.

All benefit eligible employees have the ability to enroll in the Dependent Care FSA plan.

Please refer to the FSA packet from Employee Benefit Concepts for specific plan details.

You can contribute:

- Up to **$2,750** per year to the Health Care FSA
- Up to **$5,000** per year to the Dependent Care FSA.

Below is a short listing of eligible expenses:

Eligible Healthcare Expenses
• Deductibles, Co-Insurance, Co-Pays, etc.
• Routine Physical Exams
• Mental Health / Substance Abuse Services
• Vision Expenses
• Dental Expenses
• Over-the-Counter (OTC) Medications
Eligible Dependent Healthcare Expenses
• Child Care (daycare / preschool)
• Before/After school care
• Day Camps
• In-Service days (no school)
• School Holidays / Vacation
• Transportation



Please note:

If you are currently enrolled in the Health FSA plan (2020 Plan Year) and intend to enroll in the Simply Blue PPO HSA plan for the 2021 Plan Year you MUST have a ZERO balance in your FSA. The WPS Cafeteria Plan allows employees to carry over up to $500 of unused amounts remaining in their FSA, to be used for Medical Care Expenses incurred during the next Plan Year. To prevent any carryover from interfering with your HSA eligibility, you will be given an opportunity to irrevocably elect to waive (decline) the carryover of any Health FSA amounts that are unused as of the end of the current Plan Year. You will be required to sign a waiver form prior to the end of the 2020 Plan Year.

Important Notifications

Change in Status or Special Enrollment



You may qualify for a special enrollment if certain events occur in your life:

- If you decline coverage for yourself and/or your dependents (including your spouse) because you are covered under another health plan, you may be able to enroll yourself and/or your dependents in the plan if you experience an involuntary loss of that coverage (e.g., spouse loses his/her job, divorce).
- 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 in the plan.

In either situation, you must request enrollment through the Employee Benefits Department within 30 days after the special enrollment event as described above. If you enroll as the result of a special enrollment event, coverage will be made effective on the date of the event.

Newborn and Mother's Health Protection Act



Group health plans and health insurance issuers generally 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 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 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 issuers 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 (or 96 hours).

Women's Health & Cancer Rights Act



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

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis;
- Physical complication during all stages of mastectomy, including lymph edemas.

The plan may not:

- Interfere with a woman's right under the plan to avoid these requirements;
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and co-insurance requirements consistent with other coverage provided under the plan.

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The information contained in this summary should in no way be construed as a promise or guarantee of employment or benefits. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this notice and the actual plan policies, the policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, and policies available from the HR Department.

Arthur J. Gallagher & Co.