Open Enrollment is November 15-December 3, 2021

Benefit Enrollment Guide
Wyandotte Public Schools

Wyandotte Public Schools
639 Oak St
Wyandotte, MI 48192

Full Time Administrators & Central Office

WELCOME

Welcome to the Wyandotte Public Schools (WPS) 2022 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 offer four 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 one of the Simply Blue High Deductible BCBSM Health Plans**
- **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, 2022**, will be held **November 15-December 3,2021**.

Prior year medical plan elections will rollover. If you want to change your medical plan or elect an FSA, HSA or Dependent Care Account you must complete a paper enrollment form and return it by December 3rd.

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 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**	**Simply Blue PPO HSA $2,000/$4,000 Plan**
	In-Network	**In-Network**	**In-Network**	**In-Network**
Deductible per calendar year				
Individual	None	$1,000	$1,400	$2,000
Family (two or more)	None	$2,000	$2,800*	$4,000
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	All services are subject to the deductible. See "Prescription Drugs" section for Rx copays	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	$4,000 for one person contract or $8,000 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 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	Simply Blue PPO HSA $2,000/$4,000 Plan
	In-Network	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%	Covered 100%
Annual Gynecological Exam	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Pap Smear Screening laboratory & pathology services	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Mammography Screening	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Well-baby and Child Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Immunizations	Covered 100%	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	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	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	100% after in network deductible
Urgent Care Center	$10 copay	$10 copay	100% after in network deductible	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	100% after in network deductible
Diagnostic Tests and X-rays	100% after in network	100% after in network	100% after in network	100% after in network
Therapeutic Radiology	100% after in network	100% after in network	100% after in network	100% after in network
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%	Covered 100%
Delivery and Nursery Care	100% after in network	100% after in network	100% after in network	100% after in network
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	100% after in network deductible

MEDICAL PLANS (CONTINUED)

Blue Cross
Blue Shield
Blue Care Network
of Michigan

	Community Blue PPO BCBS 100/80% with	Community Blue PPO BCBS 100/80% with $1,000/	Simply Blue PPO HSA $1,400/$2,800 Plan	Simply Blue PPO HSA $2,000/$4,000 Plan
	In-Network	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	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	Covered at 100% after deductible
Home Health Care	100% after in network deductible	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	100% after in network deductible
Voluntary Sterilization for Males	100% after in network deductible	100% after in network deductible	100% after in network deductible	100% after in network deductible
HUMAN ORGAN TRANSPLANTS				
Specified Organ Transplants—designated	Covered at 100%	Covered at 100%	100% after in network deductible	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	100% after in network deductible
Kidney, Cornea and Skin	100% after in network deductible	100% after in network deductible	100% after in network deductible	100% after in network deductible
100% after in network deductible				
Inpatient Mental Health Care & Substance Abuse	100% after in network deductible	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	100% after in network deductible
Outpatient Substance Abuse Treatment	100% after in network deductible	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	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	Covered at 100% after deductible, up to combined 12 visits
Outpatient Physical, Speech and Occupational Therapy (visit limitations	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.	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	100% after in network deductible
Prosthetic and Orthotic Appliance	100% after in network deductible	100% after in network deductible	100% after in network deductible	100% after in network deductible

PRESCRIPTION PLANS

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	Simply Blue PPO HSA $2,000/$4,000 Plan
	In-Network	In-Network	In-Network	In-Network
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				
Retail Generic	$5 Covered through CVS/ Caremark	$10	After deductible $5 copay up to	After deductible $10 copay
Retail Preferred 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.	After deductible $40 copay
Retail Non-Preferred 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.	After deductible $80 copay

*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, 2022 to December 31, 2022

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 , 2022 are:

Tiers	Full Time Administrator Plan Options	Monthly Cost
Single	**CB PPO 100/80% with $150/$300 deductible**	$237.76
2 Person	**CB PPO 100/80% with $150/$300 deductible**	$758.15
Family	**CB PPO 100/80% with $150/$300 deductible**	$878.78
Single	**CB PPO 100/80% with $1,000/$2,000 deductible**	$83.52
2 Person	**CB PPO 100/80% with $1,000/$2,000 deductible**	$388.35
Family	**CB PPO 100/80% with $1,000/$2,000 deductible**	$416.58
Single	**Simply Blue PPO HSA $1,400/$2,800 Plan**	$0.00
2 Person	**Simply Blue PPO HSA $1,400/$2,800 Plan**	$99.57
Family	**Simply Blue PPO HSA $1,400/$2,800 Plan**	$55.59
Single	**Simply Blue PPO HSA $2,000/$4,000 Plan**	$0.00
2 Person	**Simply Blue PPO HSA $2,000/$4,000 Plan**	$0.00
Family	**Simply Blue PPO HSA $2,000/$4,000 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

Blue Cross
Online Visits^{SM}

Virtual care that's always there

Convenient and affordable medical and behavioral health care you can trust

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

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

MEDICAL

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

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

BEHAVIORAL HEALTH

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

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

Start a visit or sign up today

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

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

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

Blue Cross
Blue Shield
Blue Care Network
of Michigan

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

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 2022 plan year, WPS will partially fund each employee's HSA account for those who enroll in the Simply Blue $2000/$4000 plan or enroll in Single Coverage in the Simply Blue $1,400/$2,800 plan only. Please note that this applies to benefit eligible employees only. Below is an overview of funding.

WPS 2022 Total HSA Funding	HSA Funding Date
$225 Single $450 Couple or Family	First week of January of 2022

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 **2022** calendar year is $3,650 for a single and $7,300 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 2022. 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.

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?

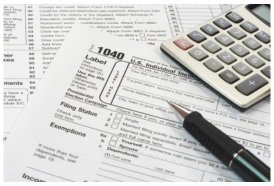
Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in the Plan ceases or the date you no longer satisfy the eligibility requirements of the plan. You need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to 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

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on ADN's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable ADN certificates and riders.

ADN
ADMINISTRATORS

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

WYANDOTTE PUBLIC SCHOOLS Dental Benefits Plan Administrators

Group # 10002

The Plan-at-a-Glance	**PPO Networks: ADN Dental Network, DenteMax**
Maximum Benefits	**Plan Year January 1st through December 31st**
Annual Maximum	$1,500.00 per eligible individual for covered class I, II and III services.
Lifetime Ortho Maximum	$1,000.00 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
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
All Other X-Rays	
Sealants	Once per tooth per 36 months, 1st & 2nd permanent molars, 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
Addition of Teeth to Partial Dentures	
Implants	Once per tooth 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	
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.**

EYEMED VISION COVERAGE

Wyandotte Public Schools- High

(Insight Network)

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	$0 copay	$0 copay	Up to $45
Retinal Imaging	Up to $39	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	$0 copay; 20% off balance over $150 allowance	$0 copay; 20% off balance over $100 allowance	Up to $85
STANDARD PLASTIC LENSES			
Single Vision	$0 copay	$0 copay	Up to $38
Bifocal	$0 copay	$0 copay	Up to $60
Trifocal	$0 copay	$0 copay	Up to $72
Lenticular	$0 copay	$0 copay	Up to $108
Progressive - Standard	$65 copay	$65 copay	Up to $60
Progressive - Premium Tier 1 - 3	$85 - 110 copay	$85 - 110 copay	Up to $60
Progressive - Premium Tier 4	$65 copay; 20% off retail price less$120 allowance	$65copay; 20% off retail price less $120 allowance	Up to $60
LENS OPTIONS			
Anti Reflective Coating - Standard	$45	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	20% off retail price	Not covered
Photochromic - Non-Glass	$0	$0	Up to $70
Polycarbonate - Standard	$40	$40	Not covered
Scratch Coating - Standard Plastic	$15	$15	Not covered
Tint - Solid and Gradient	$0 copay	$0 copay	Up to $14
UV Treatment	$15	$15	Not covered
Polarized	$0 copay	$0 copay	Up to $44
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES			
Contacts - Conventional	$0 copay; 15% off balance over $115 allowance	$0 copay; 15% off balance over $115 allowance	Up to $115
Contacts - Disposable	$0 copay; 100% of balance over $115 allowance	$0 copay; 100% of balance over $115 allowance	Up to $115
Contacts - Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $200
OTHER			
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

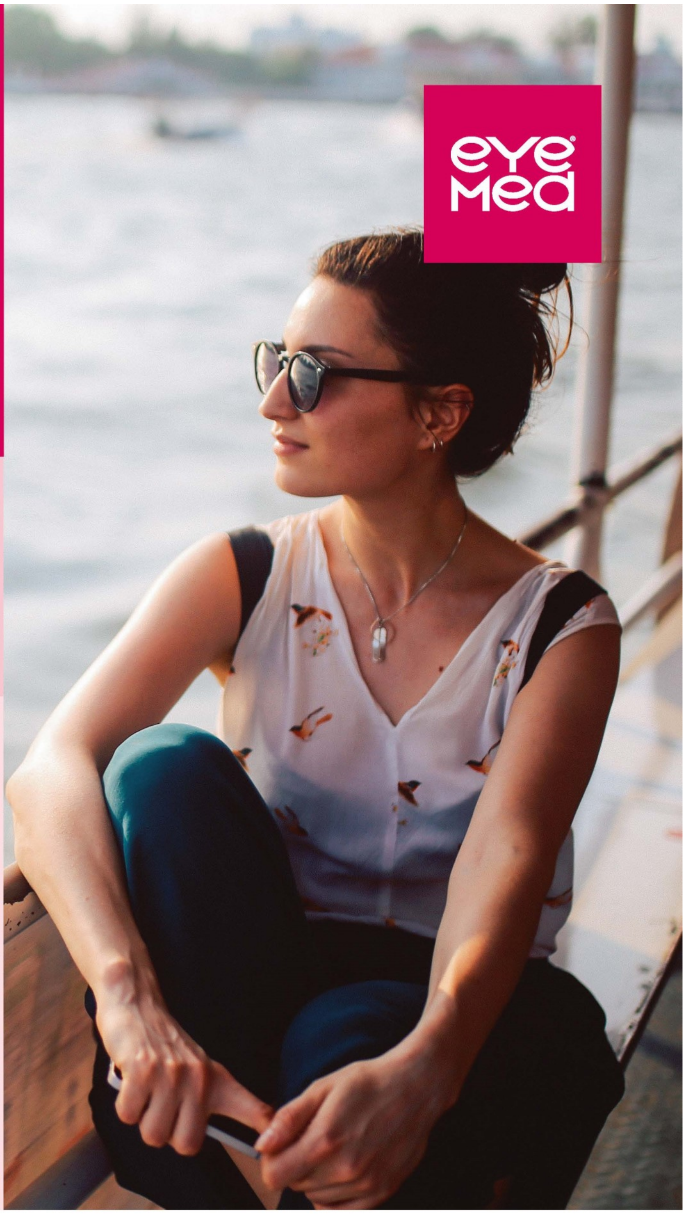
FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows member to receive either contacts and frame, or frames and lens services)

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Savings plus convenience plus choice

PLUS Providers add another layer of coverage



$0
Exam copay

$150
Frame allowance

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 866.804.0982 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

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E360 BSE

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 continued 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 1/1/22 through 12/31/22.

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 (2021 Plan Year) and intend to enroll in the Simply Blue PPO HSA plan for the 2022 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 2021 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 <u>must</u> request enrollment through the Employee Benefits Department <u>within 30 days</u> 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.

BENEFICIARY UPDATE

Update Your Life Insurance Beneficiary Information Today!

Have You Had a Major Life Event?

If you've recently tied the knot, welcomed a baby, adopted a child, undergone a divorce or suffered a death in the family, it's probably time to update your beneficiary. Imagine how your spouse may feel if your Life Insurance benefits were unintentionally left to someone else… your ex-spouse happily receives a large sum of cash while your family helplessly watches. These situations can and do happen. Update your Life Insurance beneficiary today!

Tips about Beneficiaries:

- If you do not designate a primary beneficiary, the payment may pass to your estate where it could be subject to taxes and fees, or your state law may determine who receives the benefit.
- Be sure to list a secondary beneficiary in the event your primary beneficiary precedes you in death.
- List the full name of each beneficiary instead of "son," "spouse," "wife," etc. This will avoid complications down the line.
- If you have more than one primary beneficiary – specify the percentage of proceeds each one should receive.
- Make sure contact information for your beneficiaries is up to date with your HR department.
- Think carefully about all options before naming minor children as Life Insurance beneficiaries. By law, minors cannot receive or control these assets, so funds must be distributed to someone else. Distribution may be determined by the executor or in some cases, the State. No matter the size of your estate or your Life Insurance policy, it is best to channel the assets into a trust to be distributed to your heirs according to your specific instructions. A trust is not as complicated as it sounds and can be affordable to set up.
- If you list specific beneficiaries, then your Life Insurance policy will override your will. Make sure your wishes are covered in both documents.
- If you live in a Marital Property state and you want to name someone other than your spouse, your spouse may still have a marital property claim to part or all of the death benefit. If you want to name someone other than your spouse, have your spouse sign the beneficiary statement or submit a signed and dated letter giving his or her permission.
- You can make your favorite charity or non-profit your beneficiary. Be sure to include Tax ID and contact information.
- Consider consulting an advisor (investment professional, accountant, lawyer, etc.) if you have specific questions.

NIS
National Insurance Services
Corporate office: 250 South Executive Drive, Suite 300
Brookfield, WI 53005
800.627.3660

The information provided here is not meant to be a substitute for professional advice.

NOTES

SCHOOL DISTRICT OF THE CITY OF WYANDOTTE MICHIGAN • 1853

Arthur J. Gallagher & Co.