BERKLEY
SCHOOLS

2025

Child Care Teachers

BENEFITS ENROLLMENT GUIDEBOOK

Updated October 2024

Benefits Overview

Open Enrollment for making insurance benefit changes will be from October 21st through November 10th.

Remember that the choices you make now will be effective January 1, 2025 and will remain in effect until December 31, 2025 unless you experience a qualified special enrollment event.

Enrollment Forms are due to the Benefits Department no later than Sunday, November 10, 2024.

This enrollment guide provides an overview of the benefit options available to you.

Inside this Issue.....

Medicare Part D – Prescription Drug Information

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the pages 13-14 for more details.

Required Forms and Notices

Required Enrollment Forms and Elections

Below is an overview of the required forms and/or required electronic elections based on the changes or elections you are making. These forms are posted on the district's intranet under Open Enrollment 2024.

All employees who would like to enroll in Berkley medical insurance must complete a BSD Pre-Tax Enrollment Form, due to the new insurance—WMHIP/Blue Cross Blue Shield of Michigan (BCBSM). You will receive a new BCBSM ID Card.

- Must complete the HealthEquity HSA Election Form
- Must complete the Certification of HSA Eligibility Form and the HealthEquity HSA Election Form (if changing your employee HSA contribution)

Opting out of medical coverage

- BSD 2025 Waiver of Coverage form to the Benefits Department

Flexible Spending Account (F.S.A.)

- Must complete HealthEquity Enrollment Form to the Benefits Department

Flexible Spending Accounts (F.S.A.)

Stretch your income, reduce costs and pay less in taxes. How? By enrolling in the Flexible Spending Account (F.S.A.) benefit program. This valuable benefit allows you to use your pretax dollars to pay for health care and dependent care expenses. The F.S.A. plan administrator is HealthEquity. A full F.S.A. packet of information can be found on the District's intranet under Open Enrollment 2024.

Please note, you can not have a health care Flexible Spending Account and also be enrolled in the Health Savings Account, per IRS guidelines.

Enrollment forms are due to the Benefits Department no later than November 10th.

Please Note:
Employees enrolling in The Pool BCBSM High Deductible Plans for the first time will receive a HealthEquity Health Savings Account (HSA) Debit Card.

Medical & RX Overview

Below illustrates the out of pocket expense you will experience when using the plan. The bottom of the page illustrates employee contributions or your cost to have the coverage. Enrolling in The Pool / BCBSM ENHANCED LEVEL 1650 AND ENHANCED 2000 Plans (Plans 3 and 4) makes you eligible for a Health Savings Account (HSA) see page 4 for additional details. To help minimize your employee contribution for your medical plan, Berkley School District will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your 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. Your 2025 Enrollment Election will be locked in (January 1st to December 31st). The next open enrollment period will be the month of October with a January 1, 2026 effective date. Election changes are only allowed if you experience a mid-year qualifying event.

	BCBSM PPO 1000	BCBSM PPO 2000	FLEXIBLE BLUE 1650	FLEXIBLE BLUE 2000	BCBSM PPO 500
MESSA "Equivalent" Plan	MESSA CHOICES 1000	MESSA CHOICES 2000	ABC PLAN 1 1650	ABC PLAN 2 2000	ESSENTIALS BY MESSA
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Deductible					
Based on a Calendar Year	$1,000/$2,000	$2,000/$4,000	$1,650 / $3,300	$2,000 / $4,000	$500 / $1,000
Coinsurance	0%	20%	0%	0%	20% up to Maximum of $3,000/$6,000
4th Qtr Deductible Carry Over	Yes	Yes	No	No	Yes
HSA	Not Eligible	Not Eligible	Eligible	Eligible	Not Eligible
Physician Office Services					
Office Visit	$20 copay	$30 PCP / $50 Specialist copay	Covered 100% after deductible	Covered 100% after deductible	$30 PCP / $50 Specialist copay
Emergency Medical Care					
Emergency Room	$50 copay	$150 copay	Covered 100% after deductible	Covered 100% after deductible	$150 copay
Urgent Care Visits	$20 copay physician, 20% after deductible facility charges	$60 copay	Covered 100% after deductible	Covered 100% after deductible	$60 copay
Prescription Drugs - Additional details found on www.bcbsm.com					
Generic Preferred Brand Non-Preferred Brand	$10 $40 $40	$20 $40 $80	$10 after deductible $40 after deductible $40 after deductible	$10 after deductible $40 after deductible $40 after deductible	$20 $40 $80

MONTHLY EMPLOYEE CONTRIBUTIONS AMOUNTS EXCEEDING THE HARD CAP					
Election	BCBSM PPO 1000 Plan 1	BCBSM PPO 2000 Plan 2	FLEXIBLE BLUE 1650 Plan 3	FLEXIBLE BLUE 2000 Plan 4	BCBSM PPO 500 Plan 5
Single	$141.07	$0.00	$57.85	$18.82	$1.74
Two Person	**Please contact Benefits Office for rates**				
Family					

***If you elect the option with HSA funding and leave employment mid-year you will be responsible for repaying the remaining balance of the prefunding to the District.**

Health Savings Account Overview
(Applies to ENHANCED LEVEL 1650 & ENHANCED 2000 Only)

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 Flexible Blue 1650 & Flexible Blue 2000 Plans 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 administrator. The HSA account is your property. 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 one of the Flexible Blue 1650 or Flexible Blue 2000 High Deductible Health Plans;
(b) Not be claimed as another person's tax dependent;
(c) Not be actually 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 reimbursement plan or flexible spending account, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

HSA Employer Funding

Depending on your collective bargaining agreement or employment agreement you may be eligible for HSA funding from BSD. Please note that this applies to benefit eligible employees; part time benefit eligible employees may receive a pro-rated amount.

Below is an overview of funding. You must be employed by BSD and enrolled in either the Flexible Blue 1650 or Flexible Blue 2000 Plans on the date the funding is provided in order to receive it. **Please note:** If you elect the HSA funding, you will add the following premium to your standard deduction each month:

- Single: $83.34
- 2 Person/Family: $166.67

Employee Group	BSD Total HSA Funding	HSA Funding Date and Amount
All Eligible Employees	$1,000 Single $2,000 Two-Person $2,000 Family	One Half—On or Before the Last Pay in January 2025 ($500 or $1,000) One Half—On or Before the Last Pay in July 2025 ($500 or $1,000)

Important Consideration

A HSA is an employee's property and HSA account holders are responsible for ensuring they meet the eligibility requirements for the pre-tax benefit as well as ensuring the funds are used to pay for qualified medical expense. The HSA is separate from the medical high deductible plan and is a bank account used to help pay for those expenses not covered by the plan with pre-tax dollars. We encourage you to contact your tax adviser with specific HSA questions as the impact of these accounts changes based on circumstances. The following provides an overview of the important requirements as well as some commonly asked questions.

Health Savings Account (Cont'd)

HSA Employee Funding

In addition to the Health Savings Account (HSA) funding you may elect to receive from BSD, you will have the option to fund your account with pre-tax dollars. In order to make this election you MUST indicate your election on the HealthEquity Payroll Enrollment Form.

The Statutory Maximum HSA Contribution for **2025** is $4,300 for a single and $8,550 for a family. If you are age 55 or older, you can make an additional catch-up contribution amount of $1,000 in 2025. 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 office visits 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 www.healthequity.com or by calling HealthEquity at 866-346-5800.

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. It is up to you to keep the supporting records to show the Internal Revenue Service whether you used the funds to pay qualified medical expenses.

For tax filing purposes, HSA contributions will appear on your W-2 as a line item.

EMPLOYEES WILL NEED TO COMPLETE A SEPARATE HSA BANKING FORM

Health Savings Account (Cont'd)

Frequently Ask HSA 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. Generally, the maximum contribution you may receive in a year is an indexed amount as follows: $4,300 if you have self-only coverage or $8,550 if you have family coverage for 2025.

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 on 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, 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 limit is $2,150.

(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 a 10% 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, the lower annual deductible is used to determine the contribution limit. If both you and your spouse 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.

Health Savings Account (Cont'd)

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. You will also be taxed on any earnings on the excess amounts. 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 or 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 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 in **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 the 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.

Additional Medical Benefits

1. **Virta**
Make meaningful changes to your diet with this new diabetes reversal program. If you or a family member have been diagnosed with type 2 diabetes, Virta can help you lower blood glucose levels, lose weight, and reduce your need for medication entirely.

2. **Livongo**
Receive a smart glucose meter, unlimited strips and lancets, and have access to expert coaches who provide advise on diet, lifestyle, and more to help make living with diabetes easier

3. **Omada**
Build sustainable habits to improve your health and lose weight with access to interactive digital lifestyle programs; professional health coaches; and small community groups. Available to those at risk of type 2 diabetes or heart disease.

4. **2nd.MD**
Schedule a virtual consult with specialists at top national institutions for a second opinion on diagnoses, upcoming surgeries, chronic conditions or pain, and more.

5. **Hinge Health**
This virtual exercise therapy clinic is proven to reduce back, joint and muscle pain. Hinge gives you the tools to conquer your pain, recover from injuries, prepare for or even avoid surgery, and stay healthy and pain free.

Additional Medical Benefits

Virta
Visit virtahealth.com/join/thepoolmi or scan this code with your smart phone:

Livongo
Text "GO WMHIP" to 85240 to learn more and join, visit Join.Livongo.com/WMHIP/register or call 1.800.945.4355 and use registration code: WMHIP

Omada
Visit omadahealth.com/wmhip to find out if you're eligible or scan this code with your smart phone:

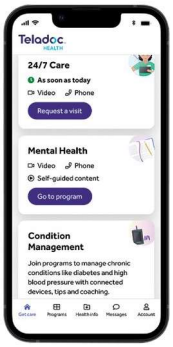
2nd. MD
Visit www.2nd.MD/wmhip or call 1.866.841.2575

Hinge Health
Visit hingehealth.com/thepool or scan this code with your smart phone:

Additional Medical Benefits

Virtual care that's always there

GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.



With **Virtual Care** by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer.

Virtual Care is included with your Blue Cross Blue Shield of Michigan plan.

24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

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 is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, 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 and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.
Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1.800.835.2362** with any questions about your account or to arrange a telephone visit.

SIGN UP TODAY

Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.

READY TO HELP

MICHIGAN

All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan.

Your Rights Under Federal Law

Special Enrollment Events/Changes in Family Status

If you decline enrollment for yourself or 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Further, 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. To request special enrollment or obtain more information, contact Laura Cannon in the Benefits Department.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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 normal 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plan providers may not require that a provider obtain authorization for prescribing a hospital length of stay of less than 48 hours (or 96 hours).

Michelle's Law

Michelle's law requires group health plans to provide continued coverage for a dependent child covered under the Plan if the child loses their benefit eligibility because of loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our Plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under our Plan and was enrolled as a student at a post-secondary educational institution.

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that: (1) begins while the dependent is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the dependent to lose student status for purposes of coverage under the Plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

Your Rights Under Federal Law (Cont'd)

Michelle's Law (Cont'd.)

If your child is eligible for this coverage continuation and loses coverage under the Plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact the Laura Cannon in the Benefits Department.

Your Rights Under Federal Law (Cont'd)

Medicare Part D—Prescription Drug Coverage

Important Notice About Your Prescription Drug Coverage Under the Plan 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 under the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage may be affected.

- You can keep your existing medical and prescription drug Plan coverage and choose not to enroll in a Part D plan. In this case, your claims continue to be paid by the Plan.
- You can keep your existing medical and prescription drug Plan coverage and enroll in a Part D plan. In this case, as an active employee (or dependent of an active employee), your Plan coverage continues to pay primary on your claims (pays before Medicare Part D).
- Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

Your Rights Under Federal Law (Cont'd)

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 under this Plan 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage… Contact Laura Cannon 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 your Employer 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).

Your Benefit Resources

Medical & Prescription Drug	**The Pool / Blue Cross Blue Shield of Michigan (BCBSM)**	877-752-1233 www.bcbsm.com
Mail Order Prescription	**Through BCBSM / OptumRx**	800-356-3477 www.optumrx.com
Specialty Pharmacy	**Through BCBSM / Walgreen's Specialty Pharmacy**	866-515-1355 www.bcbsm.com/pharmacy
Flexible Spending Accounts (FSA)	**HealthEquity**	877-924-3967 www.healthequity.com
Health Savings Account (HSA)	**Health Equity**	866-346-5800 www.healthequity.com

Notes

BERKLEY
SCHOOLS

The contents of this booklet is intended for use as an easy to read summary only. It does not constitute a contract. Additional limitations and exclusions may apply. For an official description of benefits, please refer to each carrier's official certificate/benefit guide.
For more information, please contact the Benefits Department.