Plymouth-Shiloh Local Schools Benefit Guide 2024

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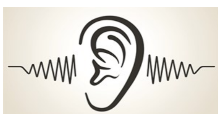
IMPORTANT NOTE: The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and Insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

Medical—SuperMed Plus

	IN NETWORK	NON NETWORK
Calendar Year Deductible	$250 Single $750 Family	$500 Single $1,500 Family
Coinsurance	90%	70%
Out-of-Pocket Maximum includes deductibles and copays	$1,000 Single $2,000 Family	$2,000 Single $4,000 Family
Primary Care Physician/Specialist	$15 Copay	Deductible—70%
Inpatient Hospital	Deductible—90%	Deductible—70%
Diagnostic Lab & X-Ray	Deductible—90%	Deductible—70%
Outpatient Surgery	Deductible—90%	Deductible—70%
Preventive Office Visits	100%	Deductible—70%
Emergency Room	Deductible—90%	
Urgent Care	Deductible –90%	Deductible –70%
Prescription Drug Coverage	Retail (30 days supply)	Mail Order (90 days supply)
Tier 1	$10	$25
Tier 2	$25	$62.50
Tier 3	$40	$100
Tier 4	20% to $100 Max	N/A

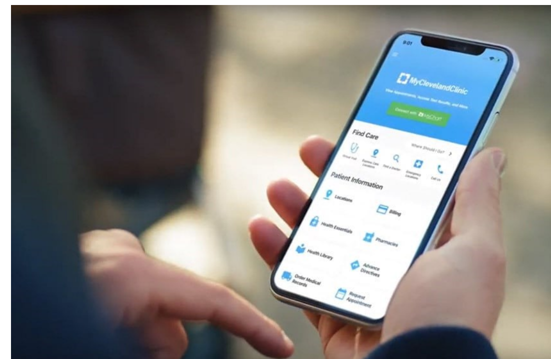


Hearing Aids: Your cost share is 10% after the deductible is met. The plan will pay up to a maximum of $3,000 every two (2) years.

IMPORTANT NOTE: All individual deductible amounts will count toward meeting the family deductible. Each member within a family plan will not pay more than the individual deductible amount.

Medical Mutual Virtual Health

Great care, whenever and wherever you are.



Life is busy. It can be hard to make time for your health. But with the **MyClevelandClinic® app,** quality healthcare is at your fingertips. You and your family can access the Cleveland Clinic services you love and trust, all from a single source.

Virtual visits:

Visit a doctor on demand, 24/7, for nonemergency concerns. Get a diagnosis or prescription online from a qualified healthcare provider in about 10 minutes. You can also schedule a virtual visit for the future. No matter how you decide to get care, our online doctor visits are affordable and convenient.

Health records:

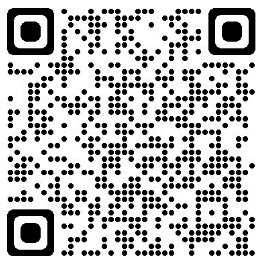
MyClevelandClinic connects you to your MyChart® account so you can access all your health information in one place. You can check on prescriptions, manage appointments, message your providers and view lab results.

Doctors:

Cleveland Clinic has more than 3,500 primary care doctors and specialists ready to help you and your family achieve good health. Use MyClevelandClinic to search for a doctor who meets your needs. Many of our providers offer both in-person appointments and virtual follow-up visits.

Locations, visitor information and more:

With hundreds of locations, including hospitals, ERs, urgent care centers and imaging facilities, Cleveland Clinic is wherever you are. Use our app to search for a location near home, work or school. Get detailed driving directions and important information



***The MyClevelandClinic® app has replaced *Express Care Online*.**

Download the new app to avoid service interruptions.

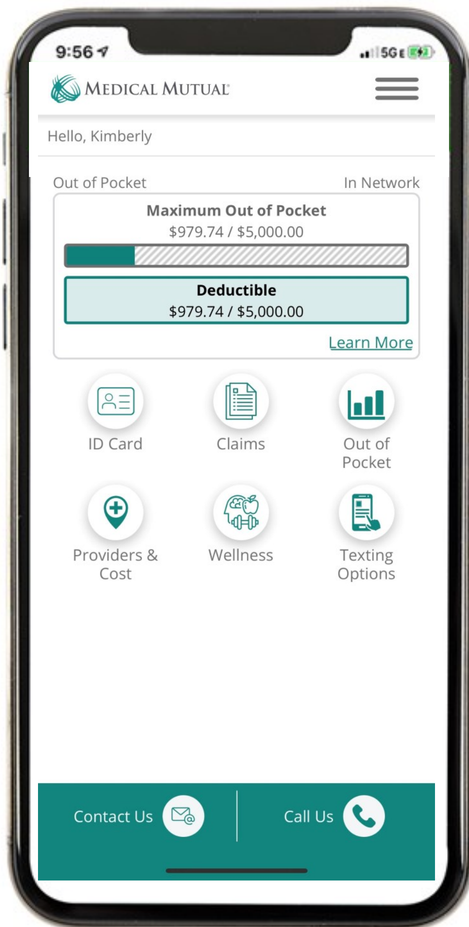
https://my.clevelandclinic.org/mobile-apps/myclevelandclinic

- Available 24/7

***What if I already signed up for Cleveland Clinic Express Care Online?**

If you have used the Express Care Online app before, you will need to download the MyClevelandClinic app and complete a one-time enrollment prior to completing a virtual visit.

Managing your health plan is easy with the MedMutual Mobile App:



Track Your Claims and Spending Information

Review your claims online, including details about the total amount billed, what Medical Mutual paid and what you are responsible for paying. You can also view other spending information, like your deductible, out-of-pocket costs and your Explanation of Benefits (EOBs).

Find a Provider and Estimate the Cost of Care

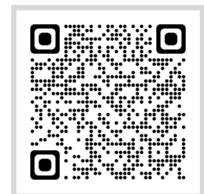
Use your device's GPS to find the nearest doctor, hospital or urgent care facility covered by your plan. Then, get directions from your current location. You can now also view quality and patient ratings for providers. With Cost Estimates on Medical Mutual's Find a Provider tool, you can get cost estimates for medical procedures, lab work, and office visits and view your estimated out-of-pocket costs based on your plan benefits.

Access Your ID Card

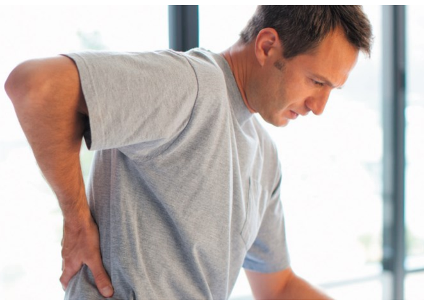
You always have your ID card with you with our app. View the front and back of your card and call any of the phone numbers listed with just a tap. You can also email and fax your card to your provider.

Download the Mobile App

Use your smart phone to scan the QR code:



Understanding your options can help you save time and money



When it comes to taking care of yourself or your loved ones, you want to get the best care as quickly and affordably as possible. When you are ill, injured or feeling like you need immediate care, always call your primary care physician (PCP) first. If you can't reach your PCP or you don't have time for an office visit, you have options.

Symptom Reference Chart

	ER/911	Urgent Care	Convenience Clinic	Primary Care Physician	Telehealth
Allergic reactions*	●	●		●	
Allergies		●	●	●	●
Annual preventive care visit				●	
Asthma		●		●	
Back pain (minor)		●	●	●	
Bleeding (heavy)	●				
Broken bone (major)	●				
Broken bone (minor)		●		●	
Bronchitis		●	●	●	●
Change in vision (sudden)	●				
Chest pain	●				
Cold and flu symptoms		●	●	●	●
Cut/burn (major)	●				
Cut/burn (minor)		●		●	●
Ear infection		●	●	●	●
Head injury (severe)	●				
Infection		●		●	
Insect bite		●		●	●
Pink eye		●	●	●	●
Rash		●		●	●
Respiratory infection		●	●	●	●
Shortness of breath	●				
Sinus problems		●	●	●	●
Spinal injury	●				
Sprain or strain		●		●	●
Trouble speaking (sudden)	●				
Urinary tract infection		●	●	●	●
Vaccinations (also flu shots)			●	●	
Wheezing		●		●	
X-ray		●		●	

Telehealth A service that allows you to connect with your provider virtually using a smart phone, tablet or computer.

Convenience Clinic A walk-in clinic located in some drug and grocery stores, staffed by a physician's assistant or nurse practitioner.

Urgent Care A walk-in clinic that saves time and money compared to an emergency room.

Nurse Line A free call-in service, providing24/7 access to registered nurses for answers to your health-related questions. Call 1-888-912-0636.

Emergency Room (ER) Provides 24/7 emergency care. ER visits for non-emergency symptoms may result in long wait times and higher costs.

WW (formerly Weight Watchers)

Did you know that Medical Mutual of Ohio (MMO) members save almost 50% off the regular cost of the membership? You can choose from digital (web-based) or Digital+ Studio (formerly Meetings) programs to help achieve your health goals. For more information call 1-800-251-2583 any time, seven days a week and leave a detailed message or visit **www.MedMutual.com/WeightWatchers.**

Diabetes

At no cost to you or you covered loved ones, by participating in Medical Mutual's Diabetes program, you may also receive up to **100% covered essential diabetes testing supplies (e.g. meters and supplies)**. There is no out-of-pocket cost for program participation. They provide education and support from a health coach and phone sessions with a dietician or diabetic educator. **Call 1-800-861-4826 and select option 2 to check eligibility and enroll.**

Tobacco QuitLine

As part of the health plan, you have access to Medical Mutual's QuitLine program to get one-on-one coaching, personalized plan and educational materials with no out-of-pocket cost to you. You may even qualify for nicotine patches or gum at no cost. **Learn more by calling 1-866-845-7702.**

Chronic Condition Management Programs

You and your covered dependents also have access to health coaches at Medical Mutual (at no cost) to receive guidance and for the following conditions: Asthma, Coronary Artery Disease, Diabetes, COPD, and Heart Failure. **MMO's Chronic Condition Management health coaches are available at 1-800-590-2583 .**

Additional Covered Services

- **Women's Preventive Services** including assistance and training in breast or bottle feeding, breast pumps and no-cost contraceptives for FDA-approved items, and bone density screenings.
- **Chiropractic Visits** are covered at 100% after you meet your deductible and are limited to 12 visits per year.

The Northmor's medical plan includes Medical Mutual's specialty drug savings program called SaveonSP. SaveonSP reduces your out-of-pocket cost to $0 by maximizing manufacturers' prescription drug copay assistance on more than 170 specialty medications filled through Acreedo (owned by Express Scripts) or Gentry Health Solutions.

When you fill a specialty medication covered by SaveonSP, you will be asked to opt into the program, or you may call **(800) 683-1074** to participate. Note: The drug list is subject to change.

Medical Mutual's New Digital Therapy Programs

Relieve aches + pain from the comfort of your own home

Meet Sword, a digital physical therapy program designed to help you overcome your joint, back or muscle pain—all from home. A NEW Program has been added to Medical Mutual's Chronic Condition Management Program. It is designed to help members with musculoskeletal conditions *(i.e.: back pain, neck & shoulder pain; and pain from arthritis)*.

Here's how it works

Pick Your PT

Thanks to your dedicated PT, your Sword program is entirely customized to you, your goals and your abilities.

Get Your Sword Kit

Your kit comes with your own tablet, and will provide you and your PT with real-time feedback.

Stay Connected

Chat 1:1 with your PT anytime. They'll check in, monitor your progress, and adjust your program as needed.

Feel the Relief

Complete your exercise sessions whenever is most convenient for you. Then feel pain relief for yourself.

join.swordhealth.com/medmutual/register

- *Licensed physical therapists (PT)*
- *Easy-to use technology*
- *Convenient*
- *No additional cost*

Scan the QR code to register

Next– generation, Pelvic-Health Program from Home

Also, another **NEW** program is the Digital pelvic-health care program addressing pelvic disorders such as urinary leakage, bowel issues, bloating, pressure, pelvic pain & more.

Pelvic Disorders

Sexual Health

Bowel/Bladder Disorders

Pregnancy

Postpartum

Menopause

Here's how it works

1. **Enroll Now**

   join.hibloom.com/MedMutual

2. **Meet your Pelvic Health Specialist**

   You will discuss your pelvic health including conditions and history.

3. **Receive your Bloom Kit**

   Your Bloom kit will be shipped to you and you will connect to the Bloom App.

4. **Start Your Journey**

   With your program and your kit, you'll start your journey to better pelvic health.

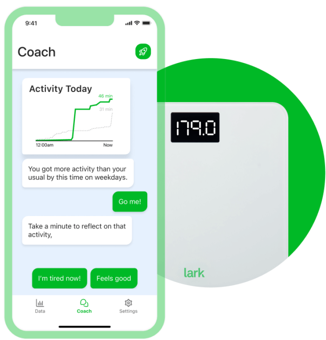
Scan the QR code to register

IMPORTANT NOTE: Bloom is available at no additional cost to all US-based Medical Mutual members and covered dependents who are age 18+ with vaginal anatomy regardless of gender identity as part of Medical Mutual's Chronic Condition Management Program.

Achieve your health goals thanks to personalized care, right from your smartphone.

Lark is like having a coach in your pocket, available 24/7 to give you personalized advice to meet your health goals. Whether you want to lose weight, stress less, prevent disease, quit tobacco, or stay healthy, Lark has a program for you.

A Program for everyone



Diabetes Prevention

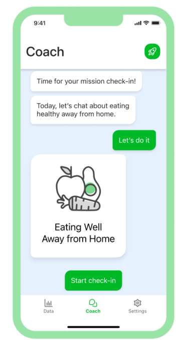
Did you know that nearly 1 in 3 American adults has prediabetes, but almost 90% of them don't know it? If your blood sugar levels are higher than they should be, Lark can help.

Blood Pressure Management

Is your high blood pressure under control? If you're one of the 45% of Americans with hypertension, Lark can help.

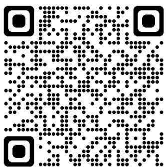
Diabetes Management

Having diabetes can feel scary, even if you visit your doctor regularly. Lark can help make small changes that over time can lower your blood glucose and A1c levels.



Wellness

Whether you want to lose weight, stress less, quit tobacco, or generally be the best you you can be, Lark's Wellness program will help you take small steps on the road to better health.



How do I register for Lark Risk Prevention/Chronic Condition Management?

Text LARKMM to 484848, or visit lark.com/medical-mutual or scan the QR code on this page with your phone.

Dental Benefits

PLAN 4	IN NETWORK	NON NETWORK*
Annual Maximum	$1,500	$1,500
Deductibles (Single/Family)	$25 / $50	$25 / $50
Preventive Services (Coverage A) Exams, Emergency exams, palliative treatment, cleanings (3 times per year), bitewing x-rays, fluoride treatment (under age 19), space maintainers (under age 19), sealants (under age 15)	Plan pays 100% (deductible does not apply)	Plan pays 100% (deductible does not apply)
Basic Services (Coverage B) Full mouth x-rays, Fillings (posterior composites covered), simple and surgical extractions, oral surgery, general anesthesia, periodontics, endodontics (root canals), denture relines and rebases, adjustments & repairs to dentures, crowns	Plan pays 80% (deductible applies)	Plan pays 80% (deductible applies)
Major Services (Coverage C) Crowns, onlays, post and core; complete and partial dentures; fixed bridge work	Plan pays 50% (deductible applies)	Plan pays 50% (deductible applies)
Orthodonics (Coverage D) Dependent children to age 23; no adult coverage	Plan pays 50% (deductible does not apply)	Plan pays 50% (deductible does not apply)
Orthodontics Lifetime Maximum	$1,250	$1,250

*When you go out of the network, you may be subject to balance billing as the providers are not contracted with TruAssure.

Your TruAssure group dental plan is offered in association with the DentaMax Plus dental network arrangement, which includes participating dentists from the DenteMax, United Concordia and Connection dental networks. In-Network services are paid off the PPO fee schedule. Out-of-network services are based on the 90th Reasonable & Customary percentile of R&C fees.

This is a brief summary of your dental plan and the services it covers. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions or non-covered services, please refer to your certificate of coverage or contact TruAssure.

TruAssure Member Portal—Dental

Get real time benefit and claim information 24 hours a day, seven days a week online through the Member Portal at truassure.com. With the Member Portal, you can find everything you need to know about your and your covered dependents' benefits, including:

- Plan summaries
- Claim status
- Benefit Levels
- Payment information
- Automatic payment enrollment
- Explanation of Benefits (EOBs)
- Printable ID Cards
- Provider search
- Additional TruAssure resources

To register for the TruAssure Member Portal, you need to:

1. Go **www.truassure.com** and select "Members."
2. Select "New member? Please sign up for an online account here." from the Member Sign In page.
3. Complete the online registration. Enter the primary enrollee's first and last name (the name must appear exactly as you entered during enrollment; e.g., "Bob" may be "Robert"), the assigned subscriber ID, and date of birth. Create your username by entering your email address and select a password.
4. Once registered, you can easily access your and your covered dependents' benefits and claims information, find a provider, print a temporary ID card, sign up to receive electronic EOBs (Go Green E-Statements), view your payments and access EOB history.
5. Signing up for automatic payment through our website is easy! Simply visit the My Payment section of the TruAssure website and fill out the payment authorization form.

You can also call us at 888-559-0779 to speak with a customer service representative during normal business hours (8:30 a.m. to 5 p.m. Monday through Friday, Central Time).

truassure.com **888-559-0779** **CSI@truassure.com**

Vision Benefits

FEATURE	IN NETWORK *Member Cost*	OUT-OF-NETWORK *Reimbursement up to:*
Eye Exam	$10 Copay	$45
Prescription Glasses		
Clear Standard Lenses		
Single	$0	Up to $30
Bifocal & Blended Bifocal	$0	Up to $50
Trifocal	$0	Up to $65
Lenticular	$0	Up to $120
Progressive	Partially Covered	Up to $65
Lens Enhancements		
Polycarbonate	Covered in full for persons up to	N/A
Basic Scratch Coating	Covered in full	N/A
Frames - *Once every 24 months*		
Frames	$0 Copay;$180 allowance	Up to $70
Contacts - *Instead of Glasses—Once every 24 months*		
Conventional	$0 Copay;$180 allowance	Up to $180
Medically Necessary	$0 Copay, Paid in Full (requires prior approval)	$210

Receive up to 35% off the national average price of LASIK procedures at more than 900 locations nationwide. To schedule a free LASIK consultation, members can call **1-877-437-6105** or visit **qualsight.com/-vba**.

Discounts of over 40% on premium hearing aids, plus a $200 mail-in rebate after purchase at participating Your Hearing Network providers. A free annual hearing exam and one year of follow-up care is also included. Members can call **888-819-5333** for more details.

Out of Network Benefits: Members receive the highest level of coverage visiting an in-network provider. If they receive services from an out-of-network provider, the carrier will base reimbursement on a maximum allowed fee. If the provider charges more than the maximum allowed fee, the member will be balance billed for the difference.

Explore VBA's Member Portal **members.vbaplans.com** for all your benefit needs:

- Log in to the VBA Member Portal to confirm eligibility for services and materials.
- Use our online Provider Finder to search for doctors in the VBA network.
- Schedule an appointment with the provider and let the office know you have vision benefit coverage through VBA prior to receiving services or purchasing materials.

If your provider is out-of-network, you may submit a claim to VBA for out-of-network reimbursement.

The vision network includes some of the nation's top retailers including Boscov's™ Optical, Costco® Optical, LensCrafters®, Pearle Vision®, Target Optical® and Visionworks®.

Do you know all the advantages of VBA membership?

We partner with several other companies that provide services to better your health and wellness.

Schedule your free LASIK eye surgery exam at a credentialed LASIK surgeon near you. Save up to 35% on this FDA approved and FSA & HSA eligible procedure. Call 1-877-437-6105.

Schedule your free hearing exam and save over 40% on premium aids with the latest technology. Call 888-819-5333.

While a member card is not necessary to access your benefi ts, you can use your VBA member card so that you have all of your plan information handy whenever you visit your doctor's office.

Member Identification Card

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Cancer Insurance

AF™ **Limited Benefit Individual Cancer Insurance**

- may help ease the financial burden of cancer treatment, so you can focus on recovery
- provides benefit payments directly to you

americanfidelity.com/info/cancer

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Life Insurance

AF™ **Life Insurance** may help ensure your family is financially protected in the event of a loss. You own the policy, so you can take it with you to a different job or into retirement.

americanfidelity.com/info/life

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Term Life Insurance

AF™ **Term Life Insurance**

- is a renewable and convertible term life insurance policy for which rates are guaranteed not to increase during the initial term
- allows you to choose from 10, 20, or 30-year term periods
- is owned by you, so you can take it with you to a different job or into retirement

americanfidelity.com/info/life

Whole Life Insurance

AF™ **Whole Life Insurance**

- provides a guaranteed death benefit, cash value, and premiums up to age 121
- allows for full cash value flexibility to stop paying premiums and still have some life insurance coverage in force
- is owned by you, so you can take it with you to a different job or into retirement

americanfidelity.com/info/life

Flexible Spending Accounts

Everyone likes saving money.

Flexible spending accounts (FSA) allow you to save part of your paycheck, before taxes, to pay for eligible costs throughout the year.

Types of Accounts

- Healthcare FSAs
- Limited Purpose FSAs
- Dependent Care Accounts

Explore your savings options at americanfidelity.com/info/fsa

To calculate medical costs that may not be covered by insurance, visit americanfidelity.com/fsa-worksheet

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter bandages
- Physical exams
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Walkers/wheelchairs

americanfidelity.com/eligible-expenses

An Easy Way to Pay for Expenses

Would you like to gain tax savings when paying for medical or dependent care costs? With a Section 125 Plan, your money can be taken from your paycheck pre-tax and used for eligible costs. And since your money is taken out pre-tax, it reduces your taxable income, and allows you to take home more money in each paycheck.

How Does it Work?

Look at the example below. Jane makes $2,000 a month. Under a Section 125 Plan, Jane would have $70 more a month. That's a savings of $840 a year. To calculate your possible savings, visit americanfidelity.com/s125-calculator

Earnings & Hours	Without S125	With S125
Monthly Salary	$2,000	$2,000
Medical Deductions	*N/A*	-$250
Taxable Gross	***$2,000***	***$1,750***
Taxes (Federal & State @ 20%)	-$400	-$350
Less Estimated FICA (7.65%)	-$153	-$133
Medical Expenses	*-$250*	*N/A*
Take Home Pay	***$1,197***	***$1,267***

A savings of $840 a year

File Your Claims Faster

AFmobile®

Our mobile app is the easiest way to submit your claims and documentation. Upload documentation* directly from your device's picture gallery.

americanfidelity.com®

Filing online is convenient, secure, and provides faster claim processing than filing by paper. From your laptop or desktop, log in to file a claim and upload documentation*.

Need assistance?

Visit americanfidelity.com/fileaclaim

The Internal Revenue Code regulations require proof of eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

Prepare for Your Enrollment

Taking time to sit down and make insurance choices each year may be the last thing you want to do. At the same time, it may be one of the most important decisions you make all year. Having this information will help you make decisions during your enrollment.

Note questions you have about your available insurance options prior to enrollment.

List any medical, dental, or vision procedures you have planned for next year.

Write down what you typically spend on prescriptions. *Tip: Log in to your pharmacy's website to view your history.*

VOLUNTARY PAYROLL DEDUCTIONS

Listed below are the current payroll deductions available to all Plymouth Shiloh Local School District employees.

U.S. Savings Bonds
American Fidelity (Flexible Spending (Section 125), Cancer & Intensive Care Coverage)
Pre-Paid Legal Services
MEC Life Insurance

403(b) TAX SHELTERED ANNUITY COMPANIES

Aspire: Eric Schwieterman (419) 933-2081 Grahamassoc.com

American Fidelity: Laura Holbrook (513) 701-3171, (877) 518-2337 American Fidelity.com

403(b) *AFTER* TAX ANNUITY COMPANY

American Fidelity: Laura Holbrook (513) 701-3171, (877) 518-2337 American Fidelity.com

Aspire: Eric Schwieterman (419) 933-2081 Grahamassoc.com

457(b) DEFERRED COMPENSATION COMPANY

Ohio Deferred Compensation: Stan Mories (877) 644-6457 Ohio457.org

In order to acquire a new investment company, there must be five (5) individuals interested in the same company. The new company must also complete an Information Sharing Agreement and be a member of AFPlanServ. (These forms will be sent to the new company by the Treasurer's Office).

VOLUNTARY PAYROLL DEDUCTIONS.doc, March 2017

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.
You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special

enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Name:	Plymouth-Shiloh Local Schools
Title:	Tracy Konik, Treasurer
Address:	365 Sandusky Street
	Plymouth, OH 44865
Phone:	419-687-4733
Email:	tkonik@plymouthk12.org

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No.1210-0149
(Expires 12-31-2024)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tracy Konik at: tkonik@plymouthk12.org or 419-687-4733
.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Plymouth-Shiloh Local School District		4. Employer Identification Number (EIN) 34-6002228
5. Employer address 365 Sandusky Street		6. Employer phone number 419-687-4733
7. City Plymouth	8. State Ohio	9. ZIP code 44865
10. Who can we contact about employee health coverage at this job? Tracy Konik		
11. Phone number (if different from above)	12. Email address tkonik@plymouthk12.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full time

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse and children of full-time employees

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: October 14, 2020

Ohio School Benefits Cooperative's group health plan ("Health Plan") is required by law to take reasonable steps to ensure the privacy of your Individually Identifiable Health Information, regardless of form, whether oral, written or electronic, transmitted or maintained by or on behalf of Health Plan ("PHI"), and to inform you about:

Sec. 1 Health Plan's Uses and Disclosures of PHI;

Sec. 2 Your PHI privacy rights;

Sec. 3 Health Plan's duties concerning PHI;

Sec. 4 Your right to file a complaint with Health Plan and the Secretary of the U.S. Department of Health and Human Services; and

Sec. 5 The person or office to contact for further information about Health Plan's privacy practices and procedures.

Section 1. Health Plan's Uses and Disclosures of PHI

All Uses and Disclosures by Health Plan will be made only with your written authorization, which you may revoke at any time in writing, except as follows:

<u>Required PHI Uses and Disclosures</u>

Health Plan is required to Disclose all books, records, accounts, and other sources of information, including PHI, to the Secretary of the U.S. Department of Health and Human Services in order to allow the Department to investigate or determine Health Plan's compliance with the privacy regulations.

<u>Uses and Disclosures for which Your Authorization is not Required</u>

Health Plan may Use or Disclose PHI, without your authorization, to carry out its own *"Payment"* and *"Health Care Operations" (see definitions below)*. Health Plan may Disclose PHI, without your authorization, to health care providers for *"Treatment" (see definition below)*. Health Plan may Disclose PHI, without your authorization, to other Covered Entities and providers for their Payment activities. Health Plan may Disclose PHI, without your authorization, to other Covered Entities participating in its organized health care arrangement for Health Care Operations or to other Covered Entities having a relationship with you for limited purposes. Health Plan also may Disclose PHI, without your authorization, to the Plan Sponsor so that the Plan Sponsor will be able to carry out Health Plan Administration functions, such as Health Plan's Payment and Health Care Operations. The Plan Sponsor has amended its plan documents to protect your PHI.

Health Plan contracts with individuals and/or entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, Health Plan's Business Associates will receive, create, maintain, Use or Disclose PHI, but only after Health Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard your PHI. Business Associates have a statutory obligation to comply with the terms of such agreement and HIPAA.

"Treatment" is the provision, coordination or management of health care and related services. It includes but is not limited to consultations and referrals between one or more of your providers. (Example: Health Plan may disclose to a specialist the name of your primary physician so that they may confer concerning your health.)

"Payment" includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). (Example: Health Plan may disclose to a doctor whether you are eligible for coverage and what percentage of the bill will be paid by Health Plan.)

"Health Care Operations" include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. (Example: Health Plan may use information about your claims to audit the accuracy of its claims processing functions.)

Health Plan is prohibited from Using or Disclosing PHI that is Genetic Information for underwriting purposes.

Use or Disclosure of your PHI is also allowed without your authorization under the following circumstances:

(1) When required by law;

(2) When permitted for purposes of public health activities, including when you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law;

(3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities or if Health Plan, in the exercise of professional judgment, believes Disclosure is necessary to prevent serious harm to you or another. If Health Plan makes such a Disclosure you will, unless informing you poses a risk of harm, be promptly informed that such a report has been made;

(4) To public health oversight agency(ies) for oversight activities authorized by law, including Uses or Disclosures in: audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions and other necessary and appropriate oversight activities;

(5) When required for judicial or administrative proceedings in response to an order of court, or subpoena, discovery request or other lawful process when satisfactory assurance is given;

(6) For law enforcement purposes, when required by law;

(7) In response to a law enforcement official's request for identification/location information (including Disclosure of information about an Individual who is or is suspected to be a victim of a crime but only if the Individual agrees to the Disclosure or Health Plan is unable to obtain the Individual's agreement because of emergency circumstances and the law enforcement official makes all required representations and Disclosure is in the best interests of the Individual as determined by the exercise of Health Plan's best judgment);

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or fulfilling other duties authorized by law. Also, Disclosure is permitted to a funeral director, consistent with applicable law, as necessary to carry out his duties with respect to the decedent;

(9) For research if a review or privacy board determines your authorization is not necessary and the researcher(s) provide all required representations;

(10) To organ procurement organizations or similar entities for the purpose of facilitating donation or transplantation;

(11) When consistent with applicable law and standards of ethical conduct if Health Plan, in good faith, believes the Use or Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the Disclosure is to a person reasonably able to prevent or lessen the threat;

(12) When authorized for specialized government functions; and

(13) When authorized by and to the extent necessary to comply with worker's compensation or other similar programs established by law.

Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be required before Health Plan may Use or Disclose psychotherapy notes about you from your psychotherapist.

Your written authorization generally will be required before Health Plan may Use or Disclose your PHI for Marketing purposes.

Your written authorization will be required before Health Plan may sell your PHI.

Your written authorization will be required for all other Uses and Disclosures of your PHI except as other wise set forth in this Notice or as required or permitted by law.

If you provide Health Plan with your written authorization, you may revoke it at any time by submitting a writ ten revocation to Health Plan's Privacy Officer and Health Plan will no longer Use or Disclose PHI under the authorization. Any prior Use or Disclosure of PHI made in reliance on your authorization before revoked will not be affected by the revocation.

Uses and Disclosures that Require You be given an Opportunity to Agree or Disagree

Health Plan may Disclose PHI to your family members, other relatives or close personal friends if: (a) the PHI is directly relevant to a family member's or friend's involvement with your care or payment for your care; and (b) you have agreed to the Disclosure, have been given an opportunity to object and have not objected, or are unavailable to ask and Health Plan has determined, in the exercise of its professional judgment, that the Disclosure is in your best interests.

Section 2. Your Rights

All of your rights discussed below may be initiated by your written request to Health Plan, directed to the person and at the address indicated in Section 5 below. Health Plan may require your completion of an applicable form for each request.

Right to Request Restrictions on PHI and Disclosures

You may request that Health Plan restrict Uses and Disclosures of your PHI other than as set forth above. However, Health Plan is not required to agree to your request unless the request is to Health Plan to restrict the Disclosure for purposes of carrying out Payment or Health Care Operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

Right to Receive Confidential Communications

Health Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you clearly state that Disclosure of all or part of your PHI could endanger you.

Right to Access and Copy PHI

You have the right to access and obtain a copy of your PHI contained in a Designated Record Set, subject to certain exceptions, for as long as Health Plan maintains the PHI. The requested information will be pro vided to you as soon as reasonably possible, but no later than thirty (30) days after your request, unless Health Plan provides a written statement of the reasons for delay and the date by which it will provide the requested information, in no event more than thirty (30) additional days. If access is denied, you or your personal representative will be provided with a written denial explaining the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Health Plan does not use or maintain electronic health records, which are defined as "an electronic record of health-related information on an [i]ndividual that is created, gathered, managed, and consulted by author ized health care clinicians and staff" with respect to Individuals' PHI. However, if Health Plan were to do so, and you request to access your PHI in a Designated Record Set, then you have the right to receive a copy of such PHI in an electronic format or to have Health Plan (or its Business Associate, if appropriate) transmit such copy to any person or entity that you designate, provided that your choice is clear, conspicuous, and specific. Health Plan may charge you a reasonable, cost-based fee for providing such copy.

managed, and consulted by authorized health care clinicians and staff" with respect to Individuals' PHI. However, if Health Plan were to do so, and you request to access your PHI in a Designated Record Set, then you have the right to receive a copy of such PHI in an electronic format or to have Health Plan (or its Business Associate, if appropriate) transmit such copy to any person or entity that you designate, provided that your choice is clear, conspicuous, and specific. Health Plan may charge you a reasonable, cost-based fee for providing such copy.

Right to Amend PHI

You have the right to request that Health Plan amend your PHI or a record about you in a Designated Record Set, subject to certain exceptions, for as long as the PHI is maintained in the Designated Record Set.

> "*Designated Record Set*" includes the medical records and billing records about Individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for Health Plan; or other information used in whole or in part by or for Health Plan to make decisions about Individuals.

Health Plan will act on your request as soon as reasonably possible, but no later than sixty (60) days after your request. If the request is denied, in whole or in part, Health Plan must provide you with a written denial explaining the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services. You or your personal representative may submit to Health Plan a written statement disagreeing with the denial or require that your request and the denial be provided with any further Disclosures of your PHI.

Right to Receive an Accounting of PHI Disclosures

You have the right to receive an accounting of Disclosures by Health Plan of your PHI during the six (6) years prior to the date of your request. The form and substance of the accounting to be given you will be in accordance with legal requirements. Health Plan will act on your request as soon as reasonably possible, but no later than sixty (60) days after your request. If you request more than one accounting within a 12-month period, Health Plan will charge a reasonable, cost-based fee for each accounting after the first one.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your PHI. Evidence of authority may take one of the following forms:

- a notarized power of attorney;
- a court order of appointment of the person as the conservator or guardian of the Individual; or
- being the parent of a minor child.

Health Plan retains discretion to deny access to your PHI to a personal representative if there are any safety concerns.

Section 3. Health Plan's Duties

Privacy Notice

Health Plan is required by law to maintain the privacy of PHI, to provide participants with notice of its legal duties and privacy practices with respect to PHI, and to notify affected Individuals following a Breach of Unsecured PHI. This Notice is effective beginning October 14, 2020 and Health Plan is required to comply with the terms of this Notice. However, Health Plan reserves the right to change its privacy practices and the terms of this Notice, and to apply any such change to and make the new notice provisions effective for all PHI that Health Plan maintains, including any received or maintained by Health Plan prior to the date of such change. If there is a material change to this Notice, Health Plan will comply with the following notice requirements, as applicable:

- Health Plan shall prominently post the change or a revised Notice of Privacy Practices on any website it maintains by the effective date of the material change to the Notice of Privacy Practices, and include the revised Notice of Privacy Practices, or information about the material change and how to obtain the revised Notice of Privacy Practices, in its next annual mailing to Individuals covered by Health Plan.

- Health Plan shall provide the revised Notice of Privacy Practices, or information about the material change and how to obtain the revised Notice of Privacy Practices, to Individuals covered by Health Plan within sixty days of the material change to the Notice of Privacy Practices. Health Plan may distribute the revised Notice of Privacy Practices, or information about the material change and how to obtain the revised Notice of Privacy Practices, by inter-office or regular mail or hand delivery, but not by email or by leaving it in a central area for pick up.

Minimum Necessary Standard

When Using or Disclosing PHI or when requesting PHI from another Covered Entity, Health Plan will limit the Use, Disclosure or request to a "limited data set" to the extent practicable or, if needed, will limit the Use, Dis close or request to the minimum amount of PHI necessary to accomplish its intended purpose(s). For pur poses of compliance with HIPAA, a "limited data set" is PHI that excludes your direct identifiers (listed in 45 CFR §164.514(e)(2)) or those of relatives, employers, or household members.

The minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for Treatment;
- Uses or Disclosures made to you;
- Uses or Disclosures made pursuant to your authorization;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or Disclosures that are required by law; and
- Uses or Disclosures that are required for Health Plan's compliance with legal regulations.

This Notice does not apply to information that has been de-identified. "De-identified information" is information that does not identify an Individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an Individual.

Breach

If you are affected in the event that Health Plan or a Business Associate of Health Plan has a Breach of Unsecured PHI, Health Plan must notify you by regular mail without unreasonable delay and in no case later than sixty (60) days after discovering the Breach. If you are one of more than five hundred (500) residents of a State or jurisdiction whose Unsecured PHI is, or is reasonably believed to have been, accessed, acquired, Used or Disclosed as a result of a Breach, then Health Plan must notify you, the Secretary and prominent local media outlets in your State or jurisdiction of the Breach.

"Breach" means the acquisition, access, Use, or Disclosure of PHI in a manner not permitted under HIPAA's privacy rules, which compromises the security, or privacy of the PHI.

"*Unsecured PHI*" is PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through encryption, destruction or other methodologies that may be approved by the Secretary.

Exceptions to Breach

- Any unintentional acquisition, access, or Use of PHI by a workforce member or person acting under the authority of Health Plan or Business Associate of Health Plan, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted by HIPAA.
- Any inadvertent Disclosure by a person who is authorized to access PHI at Health Plan or Business Associate of Health Plan to another person authorized to access PHI within Health Plan or the same Business Associate of Health Plan, or organized health care arrangement in which Health Plan participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted by HIPAA.

- A Disclosure of PHI where Health Plan or Business Associate of Health Plan has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

Section 4. Your Right to File a Complaint with Health Plan or DHHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with Health Plan by sending your complaint in writing to Ohio School Benefits Cooperative, Attention: Dr. Richard Murray, Privacy Officer, 205 North Seventh Street, Zanesville, Ohio 43701-3709.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. Health Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at Health Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, or if you would like to make requests of Health Plan or receive sample forms for the exercise of your legal privacy rights, you may contact Health Plan's Privacy Officer, Dr. Richard Murray, at Ohio School Benefits Cooperative, 205 North Seventh Street, Zanesville, Ohio 43701-3709, phone: (740) 452-4518.

Conclusion

PHI Use and Disclosure by Health Plan is regulated by a federal law known as HIPAA (Health Insurance Portability and Accountability Act of 1996) as amended, including without limitation the amendments in the American Recovery and Reinvestment Act of 2009, and the implementing regulations. You may find these rules, as well as the capitalized terms not defined in this Notice, at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations. If a Use or Disclosure required or permitted by this Notice is prohibited or materially limited by state privacy or other applicable laws, Health Plan may be required to follow those state or other applicable laws. You have the right to obtain a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically.

2024 Important Notices Relating to Your Benefits Coverage

Newborns' and Mothers' Health Protection Act (NMHPA)

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)

Uniformed Services Employment and Reemployment Rights Act

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

- 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.

Hipaa Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

Temporary Provisions Related to COVID-19. The following federal provisions were enacted in response to the 2019 Coronavirus ("COVID-19") National Emergency. These provisions shall sunset on the dates specified below, or as specified in any further COVID-19 legislation or regulatory guidance.

<u>Deadline Extensions for Certain Participant Actions</u>

In accordance with federal guidance, the Plan Administrator shall disregard the period from March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by the Agencies in any future notice ("Outbreak Period") when determining the deadline for any of the following participant actions:

Special Enrollment: The 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment.

Medicaid and the Children's Health Insurance Program (CHIP)

If you or your dependent(s) are not currently enrolled in Medicaid or CHIP and you think your dependents might be eligible, you can contact the Ohio Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. You have 60 days to request coverage after it is determined you are eligible for premium assistance.

The State Based Exchanges

Under the PPACA a federally-operated Exchange, or Marketplace, was established for individuals to purchase health insurance. Your company provides employee healthcare benefits that meet the minimum value and affordability standards of the PPACA. Therefore, if you are eligible for healthcare benefits, you will not qualify for federal subsidies or tax credits through Marketplace enrollment.

Medicare Prescription Drug Notice

Important Notice from Ohio School Benefits Cooperative About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ohio School Benefits Cooperative and the prescription drug coverage available since January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Since January 1, 2006, Medicare prescription drug coverage has been available to everyone with Medicare.**
2. **Medical Mutual has determined that the prescription drug coverage offered by Ohio School Benefits Cooperative is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.**
3. **Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's prescription drug coverage, and wondered how it would affect you. Medical Mutual has determined that your prescription drug coverage with Ohio School Benefits Cooperative is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Since January 1, 2006, prescription drug coverage has been available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for higher monthly premiums.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from October 15, 2024 through December 7, 2024. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each subsequent year, you will again have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th.

If you do decide to enroll in a Medicare prescription drug plan and drop your Ohio School Benefits Cooperative prescription drug coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with Ohio School Benefits Cooperative and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with Ohio School Benefits Cooperative and don't enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's 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 as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage…

Contact the person listed below or your school district's benefits office for further information. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available 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 prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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

Remember: Keep this notice. If you enroll in one Medicare, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: September 20, 2024
Name of Entity/Sender: Ohio School Benefits Cooperative

Contact--Position/Office: Danielle Devoll, Treasurer

Address: 205 N. Seventh Street, Zanesville, Ohio 43701
Phone Number (740) 452-4518 x1139

Medical Coverage at Age 65?

Whether entering retirement or choosing to continue their career, individuals age 65 and older have an important decision to make regarding Medicare. For many who continue working, Medicare may be a beneficial option to consider. Advanced planning will ensure that you are on the best medical plan, whether you continue under your employer plan or enroll in Medicare.

If you are still working after age 65 and have creditable insurance through your company, you may not need to sign up for Medicare. We would suggest that you compare the benefits you have through your employer (detailed in this Benefit Guide) and those offered by Medicare to see which plan is better for you and your family. Please note: If your employer has less than 20 total employees, you are required to elect Part B when you reach Normal Social Security Retirement Age (66-67, based on when you were born), as your employer plan will pay secondary to Medicare.

Once you reach Normal Social Security Retirement Age (ranging from age 66 to 67, depending on your birthday), if you elect to receive social security benefits, you will be automatically enrolled in Medicare Part A and Part B. You can also actively enroll in Medicare Part A at age 65 prior to enrolling for Social Security benefits. Medicare Part A usually has no cost to the member. Part A covers hospital, skilled nursing care and hospice. If you have medical claims, Medicare will coordinate with your employer plan. HSA plan members should not enroll in Part A as contributions into an HSA account are not allowed for those covered under Medicare.

When you are ready to leave your employer plan, you will need to sign up for Medicare Part B (which covers basic medical) and Part D (which covers prescriptions). There are specific time frames for each based on Medicare guidelines. Eligible Medicare members elect supplemental coverage through a Medicare Supplemental Plan or an Advantage plan to cover many expenses that Medicare does not.

The Medicare enrollment process can be confusing, with complex rules and varying eligibility requirements. To provide additional support, The Fedeli Group has partnered with KAZ Company, a premier Medicare insurance agency, to help you understand these options. KAZ Company works with all major Medicare supplement and Medicare Advantage carriers, providing you an array of options to meet your needs. There is no cost to engage with a KAZ agent.

If you have any questions on Medicare, please contact KAZ Company at: 216-901-9300 or **office@medicareplansneo.com**, and they can help you determine the best option for you.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

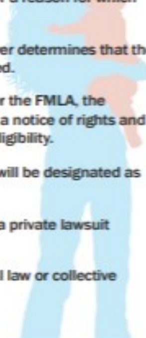
- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.



Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

IMPORTANT NOTICE

As a member of Ohio School Benefits Cooperative, your school district provides health care benefits to eligible employees and dependents through Ohio School Benefits Cooperative's group health plan. Below is important information regarding your health care benefits.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact the Benefits Office at your school district.

Contacts

Medical Mutual—Medical

Policy: 879660

Toll-free: (800) 382-5729

App: www.medmutual.com

Web: www.medmutual.com

TruAssure — Dental

Policy: 20223

Toll-free: (888) 559-0779

App: www.truassure.com

Web: www.truassure.com

Vision

Policy: 5020

Toll-free: (800) 432-4933

Web: www.vbaplans.com

American Fidelity—Voluntary Disability,

Accident, Cancer, Critical Illness,

Flexible Spending & Life Insurance

Toll-free: (877) 518-2337

Laura.Holbrook@americanfidelity.com

Plymouth—Shiloh Local Schools

365 Sandusky Street

Plymouth, OH 44865

Phone: (419) 687-4733

Fax: (419) 687-1541

https://plymouthshilohsd.org/

The Fedeli Group

Crystal Dean, Client Manager

Phone: (216) 643-6968 direct

Email: Cdean@thefedeligroup.com

2024 Plymouth-Shiloh Local Schools

Benefit Guide

CREATED BY : THE FEDELI GROUP

10/23/2024

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