EXPLORE YOUR **BENEFITS**

BROWN COUNTY SCHOOLS BENEFITS CONSORTIUM
DISTRICT: EASTERN LOCAL SCHOOLS
2021 BENEFITS ENROLLMENT GUIDE-COBRA

YOUR BENEFITS **GUIDE**

Benefits Open Enrollment.........................3
Contact Information....................................4
Health Plan 5
Dental Plan 6
Vision Plan...7
Questions & Answers...................................8
Compliance Notices.....................................9

YOUR ENROLLMENT CHECKLIST

PLAN	✓	Review this brochure to understand your 2021 benefit options.
DECIDE	✓	• Think about you and your family's benefit needs for the coming year. • Decide which options are best for you and your family.
ENROLL	✓	Make your benefit elections from October 1, 2021 - October 30, 2021.

ELIGIBILITY

If you work on a full-time basis, you are eligible for all benefits. As such, you may enroll dependents in the medical, dental and vision plans.

Eligible dependents include:

- Spouse
- Dependent children who have not attained age 26 for medical; unmarried dependents up to age 23, or up to age 25 if full-time student for dental; unmarried dependent up to age 20, or 23 if a full-time student for vision
- Dependent children of any age if they become mentally or physically incapable of self-support before age 19 and remain incapacitated and enrolled in the plan

BENEFITS OPEN ENROLLMENT **10/1/2021 – 10/30/2021**

As a Brown County Schools Benefits Consortium COBRA participant, you are vital to our success. That is why we offer a comprehensive array of benefits—spanning medical, dental, vision, and life insurance—all of which are designed to help you achieve well-being. You will have the opportunity to change your benefit decisions during Open Enrollment, which takes place October 1, 2021 - October 30, 2021. Decisions that you make will take effect November 1, 2021.

Unless you experience a qualifying event during the year, Open Enrollment is the only time you can make changes to your benefit decisions. That is why it is so important to carefully review your options and make sure they meet the needs of you and your family.

IMPORTANT REMINDERS

Open enrollment is your chance to:

- Change, elect, or drop medical, dental, and/or vision coverage.
- Add or remove a dependent to your benefits.

If you do not make any changes to your current elections, those elections will remain the same for the new plan year.

HERE'S WHAT'S CHANGING:

Dental: Effective 11/1/2021 Dental Care Plus/DentaQuest will be offering a PPO option. This is not replacing the HMO option, but will offer out of network benefits that the HMO does not.

YOUR BENEFIT CONTACTS

BENEFIT	VENDOR	CONTACT INFORMATION
Medical / Prescription Drug Plan	United Healthcare / Optum	Member Services: 1-866-633-2446 Care 24: 1-888-887-4114 Claim Address: United Healthcare, PO Box 30555, Salt Lake City, UT 84130-0555 Website: www.myuhc.com
Dental	Dental Care Plus	Member Services: 1-513-554-1100 Claim Address: Dental Care Plus 100 Crowne Point Place, Cincinnati, OH 45241 Website: www.dentalcareplus.com
Vision	Vision Service Plan (VSP Signature Network)	Member Services: 1-800-877-7205 Claim Address: Vision Service Plan, P. O. Box 997105, Sacramento, CA 95899-7105 Website: www.vsp.com
Benefit Consultant / Claims Advocate	Marsh McLennan Agency	Claims Manager: Leslie Hayes Phone: 513-707-1751 Email: leslie.hayes@marshmma.com Client Advisor: Michelle Barnes Phone: 859-816-2515 Email: michelle.barnes@marshmma.com Account Manager: Kara Valle Phone: 513-707-5024 Email: kara.valle@marshmma.com Toll Free Number: 1-800-949-1167 Address: 6279 Tri-Ridge Blvd., Suite 400, Loveland, OH 45140

COBRA Administrator:
United Healthcare Benefit Solutions
Phone: 1-800-318-5311

YOUR **MEDICAL** PLAN OPTION

Our United Healthcare Choice Plus plan allows you the freedom to use providers in and out-of-network, although the chart below only outlines the in network benefits. If you receive services out-of-network, your cost increases significantly. As a reminder, our benefits run on a calendar year basis. There are no plan changes to your medical benefits as of November 1, 2021.

Services	United Healthcare Choice Plus
Preventive Care	100%, deductible does not apply
Physician Office Visit *PCP includes family practice, general physician, internist, pediatricians, OB/GYNs	$30 copayment Primary Care Physician*; $40 copayment Specialist
Calendar Year Deductible	$1,000 per person to a maximum of $2,000 per family
Inpatient Hospitalization	80% after Deductible
Outpatient Surgery	80% after Deductible
Non-Surgical Outpatient Services for diagnostic testing, labs and x-rays (except Advanced Imaging)	100%, deductible does not apply
Advanced Diagnostic Imaging (CT Scan, MRI, Nuclear Medicine, PET Scan, etc.)	80% after Deductible
Durable Medical Equipment	80% after Deductible
Outpatient Therapies **Calendar Year Visit Limits:** **Cardiac Rehab: 36** **Pulmonary Rehab: 20** **Physical Therapy: 20** **Occupational Therapy: 20** **Manipulation Therapy: 12** **Speech Therapy: 20**	$30 copayment per visit
Urgent Care	$50 copayment
Emergency Room	$200 copayment (waived if admitted)
Out of Pocket Maximum **Per Calendar Year**	$2,250 per person to a maximum of $4,500 per family (includes copayments and coinsurance in addition to deductible)
Prescription Drugs **Retail Pharmacy (up to 30-day supply)** **Mail Order (up to 90-day supply)**	**Retail Pharmacy** $10 / $35 / $55 Specialty Rx: $75 copay **Mail Order** $20 / $70 / $110 *Specialty Rx not available through Mail Order*
Dependent Age Limit	To end of month following 26th birthday

YOUR **DENTAL** PLAN

You can choose to participate in the Dental Care Plus dental plan. Effective 11/1/2021 there will be a PPO Option in addition to the HMO option. The PPO is the best option if your dental provider is not in the DCP/DentalQuest network. **You'll need to notify your board office if you intend to move to the PPO option.** To locate a participating provider, log onto dentalcareplus.com, or call Customer Service at 513-554-1100.

TYPE OF SERVICE	COVERAGE
Preventive Services	Covered at 100%, deductible waived
Deductible, per Calendar Year	$25 per person to maximum of $50 per family
Basic Services	Covered at 80% after Deductible
Major Services	Covered at 60% after Deductible
Annual Maximum, per person, per Calendar Year	$2,500
Orthodontia (children up to age 25)	60% to $1,500 lifetime maximum
Dependent Child Age Limit	Unmarried dependents up to age 23, or up to age 25 if full-time student

YOUR **VISION** PLAN

You can choose to participate in the VSP vision plan . There are no changes to benefits for 2021. To locate a participating VSP Signature provider, please log onto www.vsp.com, or call Member Services at 1-800-877-7205. The chart below outlines the in-network benefits. By seeking care from an in network provider allows you to maximize your plan benefits. Your policy also contains a reimbursement for services received out of network, but the claim needs to be filed by you (the provider will not file the claim). For out of network services, please obtain an itemized receipt from your vision provider, and contact VSP for an out of network vision claim form.

TYPE OF SERVICE	COVERAGE
Well Vision Exam *(every 12 months)*	$5 copayment
Retinal Screening	No more than a $39 copayment on routine retinal screening as an enhancement to a Well Vision Exam
Lenses *(every 24 months)* - Single Vision Lenses - Lined Bifocal Lenses - Lined Trifocal Lenses - Polycarbonate Lenses for children	Combined with Well Vision Exam Copayment
Lens Enhancements - Standard progressive lenses - Premium progressive lenses - Custom progressive lenses *Average savings of 35-40% on other lens enhancements*	$0 copayment $80 - $90 copayment $120 - $160 copayment
Frames *(every 24 months)*	$120 allowance for a wide selection of frames; $140 allowance for featured frame brands; 20% savings on the amount over your allowance; Walmart: $65 retail from allowance
Contact Lenses *(every 24 months)* *NOTE: Contact Lenses are in lieu of Frames and Spectacle Lenses.*	$120 allowance for contacts; copay does not apply Contact lens exam (fitting & evaluation): Copay up to $60
Dependent Child Age Limit	Unmarried dependent up to age 19, or 23 if full-time student

QUESTIONS & ANSWERS

Changes that can be made effective November 1, 2021:

- Enroll or terminate individual and/or dependent coverage in the medical/dental/vision plans

Forms to be completed if making changes:

- United Healthcare Enrollment Form to change individual/dependent coverage levels in the medical plan
- Dental Care Plus Enrollment Form to change individual/dependent coverage levels in the dental plan
- VSP Enrollment Form to change individual/dependent coverage levels in the vision plan

Where do I find these forms?

- Contact United Healthcare Benefit Services for all forms.

When are the forms due and where do I return them?

- All forms are due by 10/30/21 and must be returned to United Healthcare Benefit Services.

Other Information:

- If you do not make changes to your current elections, those elections will remain the same for the new plan year.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please contact your district's board office.

YOUR **REQUIRED** ANNUAL NOTICES

HIPAA

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child. See the Plan Administrator for details about special enrollment.

CHIP

You may also enroll yourself and your dependents in a group health plan if you or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/ CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP. See the Plan Administrator for details about special enrollment.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, a covered employee's becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child's loss of dependent status (and therefore coverage) under the plan. COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

GRANDFATHERED STATUS

The Plan believes that none of the group health plans available under the Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

SPECIAL RULE FOR MATERNITY AND INFANT COVERAGE

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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers, and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes:

(i) reconstruction of the breast on which the mastectomy has been performed;

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

YOUR **REQUIRED** ANNUAL NOTICES

NOTICE REGARDING LIFETIME AND ANNUAL DOLLAR LIMITS

In accordance with applicable law, none of the lifetime dollar limits and annual dollar limits set forth in the Plan shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made.

PATIENT PROTECTION DISCLOSURE

You have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

AFFORDABLE CARE ACT CONSUMER PROTECTIONS

(a.) Coverage for Children Up to Age of 26

The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent, or a student.

(b.) Prohibition of Lifetime Dollar Value of Benefits

The Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on
the dollar value of benefits.

(c.) Your Health Insurance Cannot Be Rescinded The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage under the Plan for misrepresentation.

(d.) Prohibition of Pre-existing Conditions

Effective January 1, 2014, the Affordable Care Act of 2010 prohibits the Plan, or any insurer, from denying any health insurance claim for any person because of a pre- existing condition.

(e.) Prohibition of Restrictions on Annual Limits on Essential Benefits

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January
1, 2014, from placing annual limits on the value of essential health benefits.

(f.) Notice of Marketplace/Exchange

If this health insurance is unaffordable (your cost of the premium exceeds 9.5% of your income) as defined under the Affordable Care Act , you may have the right to subsidized health insurance purchased through an exchange/ marketplace created pursuant to the Affordable Care Act.

THE GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

WELLNESS

If your Plan includes a Wellness program that provides rewards or surcharges based on your ability to complete an activity or satisfy an initial health standard, you have the right to request a reasonable alternative should it be determined that it is not medically advisable for you to either complete the activity or satisfy the initial health standard.

MENTAL HEALTH PARITY AND ADDICTION EQUITY

The Medical Plan provides the same coverage for any mental health service as are provided for medical coverage. This means that stated medical deductibles, copays, coinsurance and out-of-pocket limits will also apply to mental health services.

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 United Healthcare/Optum 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. Brown County Schools Benefits Consortium has determined that the prescription drug coverage offered by the United Healthcare/Optum 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage through Brown County Schools Benefits Consortium, by 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 United Healthcare/Optum coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current United Healthcare/Optum coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment period.

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 United Healthcare/Optum 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 20% 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 your district's board office 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 United Healthcare/Optum 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).

Marsh McLennan Agency LLC
6279 Tri-Ridge Blvd., Suite 400
Loveland, OH 45140
859-816-2515 | 1-800-949-1167

www.marshmma.com

Disclaimer: This document is not intended to be taken as advice regarding any individual situation and should not be relied upon as such. Marsh & McLennan Agency LLC shall have no obligation to update this publication and shall have no liability to you or any other party arising out of this publication or any matter contained herein. Any statements concerning actuarial, tax, accounting or legal matters are based solely on our experience as consultants and are not to be relied upon as actuarial, accounting, tax or legal advice, for which you should consult your own professional advisors. Any modeling analytics or projections are subject to inherent uncertainty and the analysis could be materially affective if any underlying assumptions, conditions, information or factors are inaccurate or incomplete or should change.