BMCS
Health Care
Consortium

Bucks and Montgomery County Schools Healthcare Consortium appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Anytime you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD).

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WELCOME TO YOUR 2023-2024 BENEFITS GUIDE!

On behalf of the Bucks and Montgomery County Schools Healthcare Consortium, thank you for the important work that you do in our public schools. We value your important contributions to our students, communities, and colleagues.

Please use this guide as a roadmap of support for using the medical and prescription drug benefits available through our consortium. It will help you understand common healthcare vocabulary, the designs of each of our four medical plans, and a host of other supports to help you navigate the complexities of our healthcare system and receive excellent care.

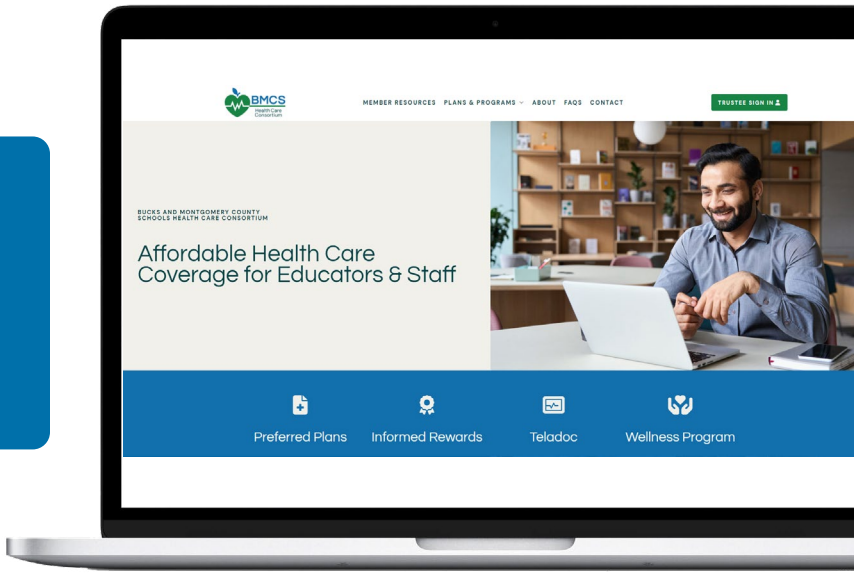
If you have questions about any of the features of our plans or services, please utilize the telephone numbers listed in this guide or contact a member of your HR department.

Best wishes for a safe and healthy school year,

Rebecca Roberts-Malamis and Bill Senavaitis

Chair and Vice Chair of the Bucks and
Healthcare Consortium

For more information on BMCS, our benefit plans, and program flyers, please visit our website: bmshc.org. Our site contains detailed information on our medical plans and carrier programs that are available to all of our members.



MEDICAL BENEFITS

Bucks and Montgomery County Schools Healthcare Consortium is committed to helping you and your dependents maintain health and wellness by providing you with access to the highest levels of care. We offer you a choice of three Open Choice POS II plans, and a POS plan through Aetna for the 2023-2024 plan year. Point of Service (POS) plans are affordable plans with out-of-network coverage. Members enrolled in the BMCS POS plan will require a referral from your primary care doctor to see a specialist.

Medical plan summary

	BMCS Open Choice® - 1		BMCS Open Choice® - 2		BMCS Open Choice® - 3**		BMCS POS	
	In network	Out of network	In network	Out of network	In network	Out of network	Referred	Self-referred
Referrals required	No	No	No	No	No	No	Yes	No
Deductible								
Individual	$0	$600	$0	$1,000	$1,100	$1,100	$0	$1,000
Family	$0	$1,200	$0	$3,000	$2,200	$3,300	$0	$3,000
After Deductible, Plan Pays	100%	70%	100%	70%	100%	50%	100%	50%
Out-of-pocket maximum								
Individual	$3,500	$7,500	$5,000	$7,500	$3,500	$10,000	$3,500	$10,000
Family	$7,000	$15,000	$10,000	$15,000	$7,000	$30,000	$7,000	$30,000
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Doctor's office visits								
Primary Care Services	$10 copay	70%, after deductible	$20 copay	70%, after deductible	$25 copay	50%, after deductible	$15 copay	50%, after deductible
Specialist Services	$20 copay	70%, after deductible	$40 copay	70%, after deductible	$50 copay	50%, after deductible	$25 copay	50%, after deductible
Preventive Care	100%	70%, no deductible	100%	70%, no deductible	100%	50%, no deductible	100%	50%, no deductible
Teladoc (General Medicine)	$0	Covered as In-Network	$0	Covered as In-Network	$0	Covered as In-Network	$0	Covered as In-Network
Routine Eye Exam	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	$25 copay (once every 24 months)	Not covered
Hospital services								
Inpatient Hospital Services	$75 per day (max of 5 copays per admission)	70%, after deductible	$350 copay per admission	70%, after deductible	$300 copay	50%, after deductible	$250 copay per admission	50%, after deductible
Outpatient Surgery	$75 copay	70%, after deductible	$200 copay	70%, after deductible	$200 copay	50%, after deductible	$100 copay	50%, after deductible
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay

	BMCS Open Choice® - 1		BMCS Open Choice® - 2		BMCS Open Choice® - 3**		BMCS POS	
	In network	Out of network	In network	Out of network	In network	Out of network	Referred	Self-referred
Urgent Care/ Non-Urgent Use of Urgent Care	$28 copay	70%, after deductible	$28 copay	70%, after deductible	$50 copay	50%, after deductible	$24 copay	50%, after deductible
Ambulance								
Emergency & Medical Transportation	100%	100%	100%	100%	**100%, after deductible**	100%, after deductible	100%	100%
Diagnostic Procedures								
Outpatient Laboratory/ Pathology	100%	70%, after deductible	100%	70%, after deductible	**100%, after deductible**	50%, after deductible	100%	50%, after deductible
Outpatient Radiology (routine radiology/ diagnostic MRI/ MRA, CT/CTA scan, PET scan)	$20 copay	70%, after deductible	$40 copay	70%, after deductible	**100%, after deductible**	50%, after deductible	100%	50%, after deductible
Therapy Services								
Physical, Occupational and Speech	$15 copay [visits 1-30] $25 copay [visits 31-60] (60 visits per calendar year for PT/OT/ST)	70%, after deductible (60 visits per calendar year for PT/OT/ST)	$20 copay [visits 1-30] $40 copay [visits 31-60] (60 visits per calendar year for PT/OT/ST)	70%, after deductible (60 visits per calendar year for PT/OT/ST)	$25 copay (visits 1-30) $50 copay (visits 31-60)	50%, after deductible	100% (up to 60 consecutive days per condition covered, subject to significant improvement)	50%, after deductible (up to 60 consecutive days per condition covered, subject to significant improvement)
Chiropractic Care	$20 copay (30 visits per calendar year)	70%, after deductible (30 visits per calendar year)	$40 copay (30 visits per calendar year)	70%, after deductible (30 visits per calendar year)	$50 copay (30 visits per calendar year)	50%, after deductible (30 visits per calendar year)	100% (100 visits per calendar year)	50%, after deductible (100 visits per calendar year)
Private-Duty Nursing	100%	70%, after deductible	100%	70%, after deductible	**100%, after deductible**	50%, after deductible	100%	50%, after deductible
Hospice and Home Health Care	100%	70%, after deductible	100%	70%, after deductible	**100%, after deductible**	50%, after deductible	100%	50%, after deductible
Durable Medical Equipment and Prosthetics	$20 copay	70%, after deductible	$40 copay	70%, after deductible	**100%, after deductible**	50%, after deductible	100%	50%, after deductible
Mental health care								
Outpatient	$20 copay	70%, after deductible	$40 copay	70%, after deductible	$50 copay	50%, after deductible	$25 copay	50%, after deductible
Inpatient	$75 per day (max of 5 copays per admission)	70%, after deductible	$350 copay per admission	70%, after deductible	$300 copay per admission	50%, after deductible	$250 copay per admission	50%, after deductible
Substance abuse treatment								
Outpatient/Partial Facility Visits	$20 copay	70%, after deductible	$40 copay	70%, after deductible	$50 copay	50%, after deductible	$25 copay	50%, after deductible
Inpatient Rehabilitation	$75 per day (max of 5 copays per admission)	70%, after deductible	$350 copay per admission	70%, after deductible	$300 copay per admission	50%, after deductible	$250 copay per admission	50%, after deductible
Inpatient Detoxification	$75 per day (max of 5 copays per admission)	70%, after deductible	$350 copay per admission	70%, after deductible	$300 copay per admission	50%, after deductible	$250 copay per admission	50%, after deductible

** Additional services subject to the OC3 plan deductible: Imaging, prosthetics, blood and blood products, infusion therapy (home, office, and outpatient).

BASIC INSURANCE TERMS

COINSURANCE: Coinsurance is your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

COPAY: A copay is a fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible but will count toward your out-of-pocket maximum.

DEDUCTIBLE: The deductible is the amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $1,100, your plan won't pay anything until you've met your $1,100 deductible for covered healthcare services subject to the deductible. Preventive care is not subject to the deductible as it is covered 100% by any medical plan option.

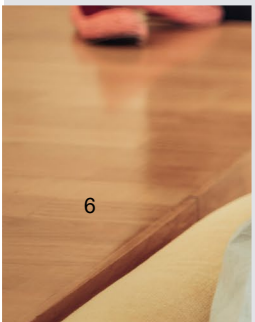
EXPLANATION OF BENEFITS (EOB): An EOB is a statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

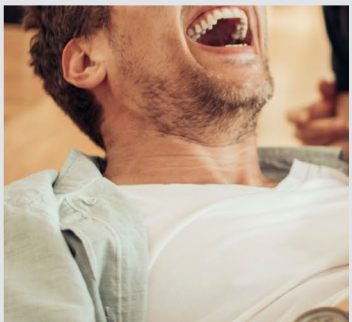
IN-NETWORK VS. OUT-OF-NETWORK: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims will be higher because you will not receive the discounts the in-network providers offer.

OUT-OF-POCKET MAXIMUM: The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have paid the specified out-of-pocket amount during a policy year, the plan pays the remaining covered services at 100%.

PREVENTIVE CARE: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include but are not limited to physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

REASONABLE AND CUSTOMARY: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.





WHERE TO GO FOR DIAGNOSTIC PROCEDURES

Locate an in-network lab

Quest Diagnostics and LabCorp are Aetna's national preferred labs. They, along with their national and specialized affiliates, offer a wide range of testing services. Patients can get everything from routine blood tests to gene-based cardiology to molecular testing.

Stay in the network and pay less! You can save on out-of-pocket costs when you get lab work done in Aetna's network. Below is an example of how in-network costs compare to out-of-network costs using the Open Choice 1 plan:*

	Quest Diagnostics and LabCorp	Out-of-Network
Lab test price	$30	$300
Patient's Coinsurance	0%	30%
Patent Pays	$0	$90

*These prices reflect an example of a routine lab test.

You can see a complete list on Aetna.com by using our provider search tool.

GET STARTED WITH YOUR SECURE MEMBER WEBSITE

Your secure member website saves you time, and helps you make more informed decisions about your health. And, you can view your most important information at-a-glance. You can:

- Find the right doctor
- See what you owe
- Know your plan
- Get valuable information
- Know costs before you go
- Get healthier

Logging in is fast, easy and convenient

You may use your Aetna member ID card or your social security number to register.

STEP 1: Go to aetna.com

STEP 2: Click on the Log In/Register link

STEP 3: Follow the simple prompts

Questions?

Call Aetna Member Services at 1-(800) 293-3536

AETNA URGENT CARE

Feeling fluish? Have a pounding headache? Hurt your back carrying the groceries? Don't spend more time and money than needed at the emergency room (ER). Consider visiting an urgent care center instead to help you feel better sooner.

Plenty of services

Urgent care centers offer care for serious medical matters that aren't life threatening. They also handle vaccinations and treat:

- Sprains and minor fractures
- Cuts that require stitches
- Bronchitis
- Lower back pain
- Headaches and more

Finding care near you is easy:

1. Log in or register at **aetna.com**
2. Click on "Find Care."
3. Select "Urgent Care."
4. Scroll down and select "Urgent Care Facilities."

Non-Emergency Services	Average ER Cost*	Average Urgent Care Cost*
Sprains	$750 - $1,000	$125 - $175
Flu	$750 - $1,000	$125 - $175
Minor Cuts	$750 - $1,000	$125 - $175
Migraines/tensions headaches	$750 - $1,000	$125 - $175

* Average retail and ER pricing. Based on Aetna average claims costs. Data accessed April 2018. For illustrative purposes only.1Urgent Care Locations, LLC. Urgent care center vs. emergency room. Available at: urgentcarelocations.com/urgent-care-101/faq/urgent-care-center-vs-emergency-room. Accessed April 4, 2018.

AETNA HEALTH APP

You're in charge

Staying healthy is important. So is keeping track of your benefits. But with everything else you have going on, managing it all can be a challenge.

The Aetna Health app can help. From finding a doctor and comparing costs to paying claims and viewing your ID card, the app is your all-in-one resource for the information you need.

See for yourself how the Aetna Health app can make it easier to manage your benefits.

- View benefits and pay claims for your whole family
- Search for providers, procedures and medications
- Locate an in-network urgent care facility
- Get cost estimates before you get care
- Track spending and progress toward meeting your deductible
- Access your member ID card whenever you need it

Download the Aetna Health App

Available on the App Store | ANDROID APP ON Google Play

INFORMED HEALTH® LINE

A 24-hour information line for your health questions, talk to a registered nurse anytime.

With the Informed Health Line, you can speak to a registered nurse about health issues — whenever you need to. Plus — it's toll-free, you can call as many times as you need (at no extra cost), and your covered family members can use it, too!

You can:

- Get information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive emails with links to videos that relate to your question or topic

Call (800) 556-1555 Today!

CVS® CAREPASS®

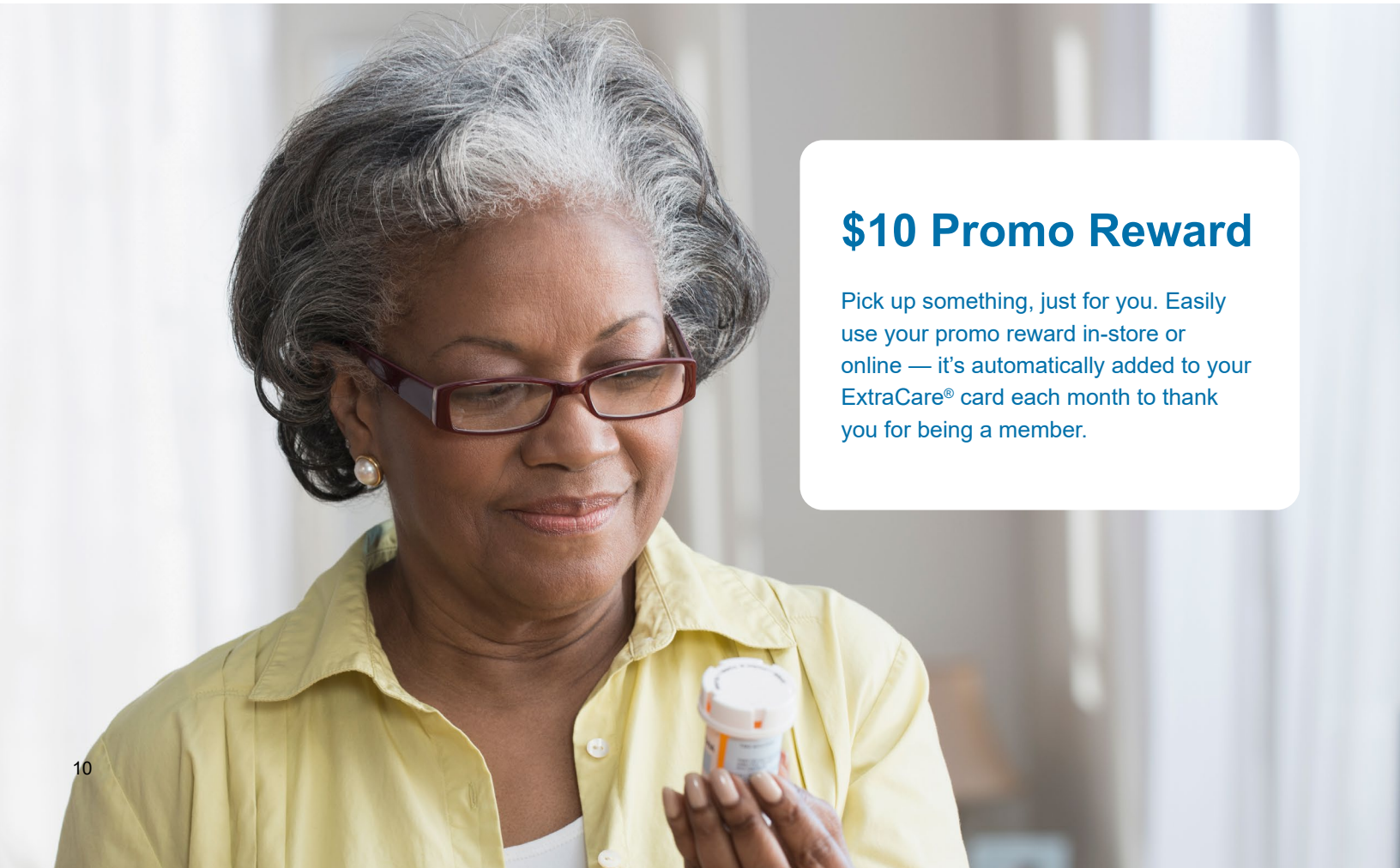
Get membership perks you'll use everyday

The CVS CarePass membership program can help you and your family stay healthy, save money and ultimately stress less. Perks like same day, no-cost prescription delivery and discounts on thousands of your favorite CVS products offer convenient ways to keep your health goals on track — and give you fewer errands to run. And with exclusive access to our 24/7 pharmacist helpline, you'll have peace of mind, too.

Why you'll be a major fan of CVS CarePass

- 24/7 access to CVS pharmacists
- Through our pharmacist helpline, you and your loved ones can receive medication support quickly
- Rx delivery on your schedule
- Get the medications you need, whenever you need them, with no-cost, same day delivery on prescriptions
- Receive 20% savings on thousands of CVS Health products
- 1- to 2-day shipping on your entire order and no minimums

To register for CarePass, log in to the Aetna Health app or your Aetna® member website.



$10 Promo Reward

Pick up something, just for you. Easily use your promo reward in-store or online — it's automatically added to your ExtraCare® card each month to thank you for being a member.

CVS HEALTH HUB

CVS.com/healthHUB

CVS® HealthHUB™ is a local health care destination that offers convenient and affordable care that you may need to help you feel your best.

Care that's convenient and reliable

- Expanded health services that can go beyond everyday care to help assist with chronic conditions, such as diabetes or sleep apnea.
- A professional care team of providers that work together to support your total health and help coordinate care and services you may need.
- Extra assistance from the pharmacist who can talk with you about screenings, support tools and services you may need to get on the path to better health.
- A care concierge who is there to guide you every step of the way and help you navigate the services and resources offered within a CVS HealthHUB location.
- And, a greater selection of health and wellness products– with everything from self-care products to durable medical equipment and supplies, to help support your total health.

MINUTECLINIC®

CVS.com/minuteclinic

The time for a solution that gives people more options to take control of their health and get the care they need — on their terms — is now.

Care that's convenient and reliable

MinuteClinic® makes it easy for you to get the care you need, when and where you need it. You can get access to all covered MinuteClinic services at no cost — not just preventive care.

- MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores and is the largest provider of retail health care in the United States — with over 1,100 locations in 33 states and the District of Columbia.
- Open every day, including evenings. MinuteClinic offers both walk-in and scheduled appointment options.
- MinuteClinic health care providers treat a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.

TELADOC

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor and therapist through the convenience of phone, video or mobile app visits. It's an affordable option for quality medical care.

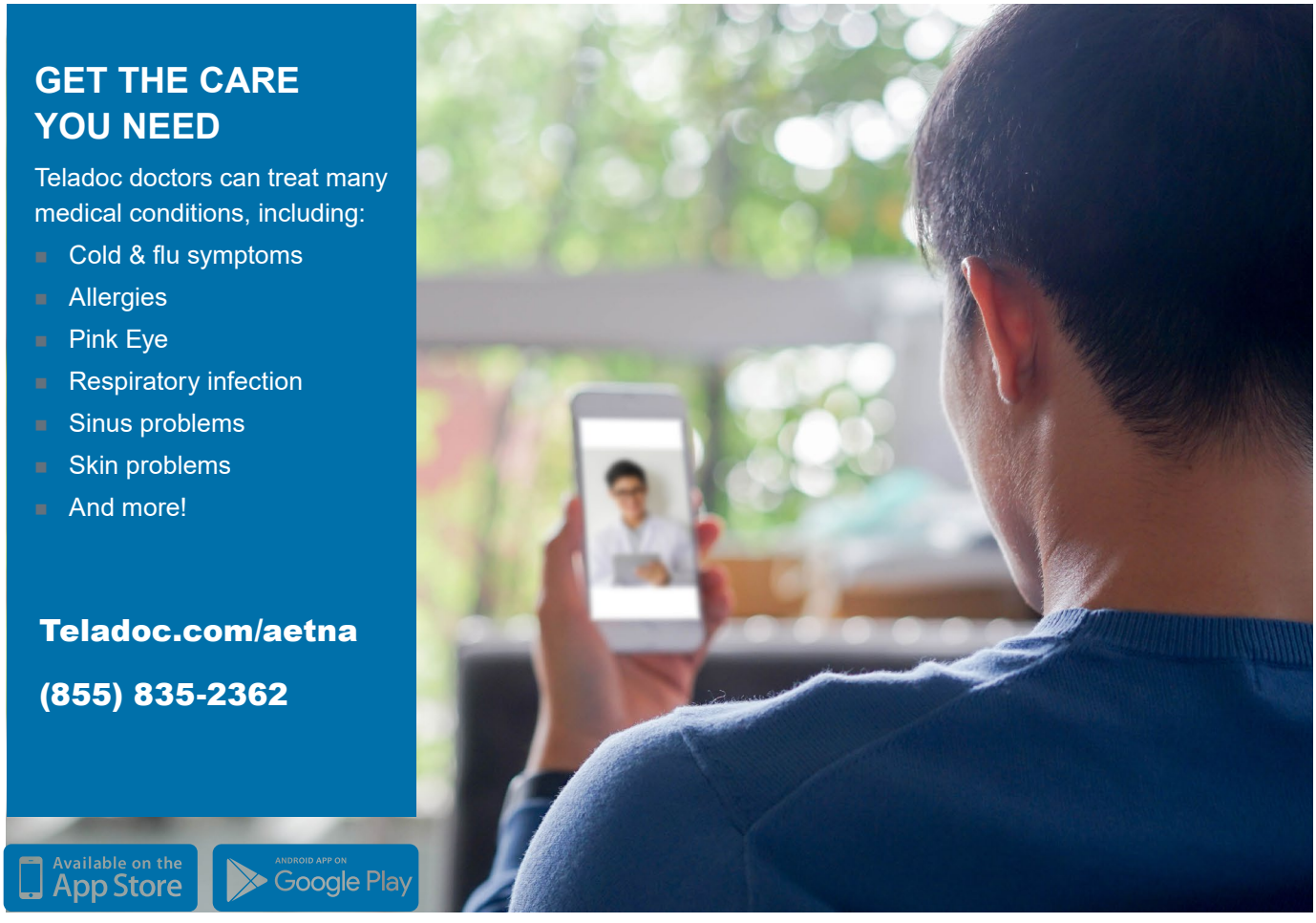
- Receive quality care via phone, video or mobile app
- Prompt treatment, talk to a doctor in minutes
- Prescriptions sent to pharmacy of choice if medically necessary
- Teladoc is less expensive than the ER or urgent care
- Meet a Therapist 7 days a week and get support for anxiety, depression, stress, and more!

Cost Comparison

General Medicine Teladoc	ER
$0	$100

*Behavioral Health and Dermatological Teladoc apply the applicable specialist copay depending on the plan.

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.



PRESCRIPTION DRUG

Please refer to your school entity HR rep to see your Prescription Drug options.

Your prescription drug plan is administered through Capital Rx. There is a dedicated Customer Care team available 24 hours a day, seven days a week that can be reached at 1-877-542-2779.

The Capital Rx suite of digital tools includes an online member portal and mobile app, giving you a personal advisor for your prescriptions in the palm of your hand.

- Find a pharmacy
- View your claims history
- Download a digital pharmacy card
- View which drugs are covered under your plan
- Track how much money you have paid towards your out-of-pocket obligations

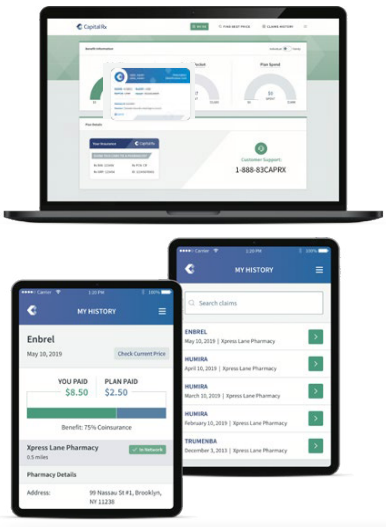
To Access The Member Website …

- Create your account and register at: https://app.cap-rx.com/register. Be sure to check your email to complete your registration.

Capital Rx Mobile App

The Capital Rx Pharmacy Benefits mobile app is a modern and user-friendly experience. It is designed to empower members to understand and manage their pharmacy benefits.

- Allows members to access the Capital Rx Formulary and other helpful tools
- Uses the latest security authentication with the ability to enable push notifications
- Keeps members informed of updated drug pricing and possible drug alternatives



- Search for the lowest cost drug at surrounding pharmacies
- Find a pharmacy
- View your claims history
- Download a digital pharmacy card
- View which drugs are covered under your plan
- Track how much money you have paid towards your out-of-pocket obligations

Walmart Home Delivery Pharmacy

Capital Rx's preferred home delivery provider is Walmart. Before prescriptions can be filled through Walmart Home Delivery, a profile needs to be setup through one of the following options.

Phone:

Call 1-877-542-2779 and follow the prompts for medications delivered to your home.

Mail:

Mail a completed order form to Walmart Home Delivery:
1025 W. Trinity Mills,
Carrollton, TX 75006

Email:

Email a completed order form to WMSRX@wal-mart.com.

Download an order form by logging into the Capital Rx Member Portal. Blank forms are available under 'Forms and Documents'.

WELLNESS PROGRAM

Lasting commitment to health and wellness means understanding that your well-being is a lifelong journey that begins with a single step. If we create habits that enhance our well-being and keep us motivated in the short term, then we will stay committed for the long term. BMCS wants to be your biggest supporter along that journey - that's why we are continuing BMCS wellness programs with the help of Aetna. Below is information on the Journeys online coaching program that gives you recommendations after you complete your health assessment.

What's Required?

Log-on or register for your secure member website at Aetna.com. You will be able to complete your health assessment through Compass.

Your Personal Health Report

Your health report gives you:

1. A risk score
2. Your top strengths
3. Your top health risks
4. Health risk grid

Personal Health Coach

Sure, it can be hard to fit healthy into your life. But we're here to support you every step of the way.

You get a line of digital coaching programs included with your health plan. All online — all personalized to your health goals — whether you're managing a health risk, overcoming an old habit, or just eating healthier.

- You choose the goals to work on
- You choose when we reach you
- You choose the pace. You're 100 percent in charge

Where Do You Want To Take Your Health Today? YOU Decide.

- Beat back pain
- Stress less
- Quit tobacco
- Get heart healthy
- Manage asthma or diabetes
- Eat healthier, and more

Simple steps to fit you. Log in at aetna.com, and look for the "Stay Healthy" icon.

MINDCHECK

Take control of your emotional health,

your emotional health contributes to your overall health!

Part of being healthy involves taking care of your feelings. For example, positive thinking is linked to health benefits that include:

- Faster recovery
- Better sleep
- Fewer colds
- Greater sense of happiness
- Longer lifespan

Find out where you stand

How do you feel? How do you want to feel? You can't plan a route to where you want to go until you know where you are.

The MindCheck online tool asks you four simple questions so you can be aware of how you're feeling. You'll be matched to a color and level to provide insight into your emotional health.

And the MindCheck site tracks your history, so you can see how your results change over time.

AETNA'S ABLETO

Manage Life's Changes

Some life events can be overwhelming. Like having a baby. Or finding out you have diabetes or heart disease.

You may also feel emotions like:

- Worry
- Depression
- Confusion
- Anger

All of these feelings are normal. But they can make it harder for you to take control and make healthy changes. And it's important to feel that you can control the health condition or life change, instead of it controlling you.

Real Help That Works

Meet face-to-face with a therapist and behavior coach using online video. Or you can simply talk on the phone, if you prefer. This removes the time and hassle of driving to appointments. Plus, you choose the times that work best for you. During the day, in the evening or on weekends.

You'll Work With Two Able To Specialists for Eight Weeks

- Once a week with a therapist to address emotional challenges like depression, stress and anxiety that can come with a medical diagnosis
- Once a week with a behavior coach to identify health goals and develop an action plan

Now it's easy to take control of your emotional health.
Simply go to mindchecktoday.com to get started.

Remember to check back often. The more you know about taking care of your emotional well-being, the healthier and happier you can be.

AETNA INFORMED REWARDS PROGRAM

Choose an eligible lower-cost medical service and get rewarded!

Want to save money and get something back, too? Choose a lower-cost medical service, and you could qualify for a financial reward.

Earn $25 to $75

Most common health care services — such as MRI scans, X-rays, colonoscopies and ultrasounds — qualify for a reward. Reward amounts vary by service.

How does it work?

Log in to your Aetna member website at Aetna.com/about-us/login.html.

1. Search for service in the “Find Care & Pricing” section.
2. Identify eligible service and activate your rewards!

It pays to save with Aetna Informed Rewards

Start earning rewards on these common medical services		
Carpal tunnel release	$75 reward	
Cataract removal	$75 reward	
Colonoscopy	$75 reward	Diagnostic, basic, preventive
CT scan	$50 reward	Abdomen; arm, elbow, wrist or hand (upper extremities); chest region; head or neck area; knee or ankle (lower extremities); spine or pelvic region
Endoscopy	$75 reward	Upper GI
Hernia repair	$75 reward	
Mammogram	$25 reward	Diagnostic or preventive
MRI	$50 reward	Abdominal region; arm, elbow, wrist or hand (upper extremities); chest region; head or neck area; knee or ankle (lower extremities); spine or pelvic region
Tonsillectomy	$75 reward	
Ultrasound	$25 reward	Abdomen; breasts; pregnancy after 14 weeks
X-ray	$25 reward	Abdomen; ankle; arm; chest; elbow; foot and toes; hand and fingers; hip; knee; leg; lower back; neck; pelvis; shoulder; upper back; wrist

Aetna Informed Rewards
Get rewarded for smart choices!

CONTACTS

Medical plan

Aetna

Member Services: (800) 293-3536
Info Health Line: (800) 556-1555
Website: aetna.com

Prescription services

Capital Rx

Customer Care Team: 877-542-2779
Website: cap-rx.com

Telehealth

Teladoc

Customer Service: (855) 835-2362
Website: Teladoc.com/aetna

NOTES

Bucks & Montgomery School Consortium

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3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Notice of Right to Designate Primary Care Provider and of No Obligation for Pre-Authorization for OB/GYN Care
6. Women's Health and Cancer Rights Notice
7. Michelle's Law Notice
    - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
8. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Bucks & Montgomery School Consortium About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM BUCKS & MONTGOMERY SCHOOL CONSORTIUM 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 Bucks & Montgomery School Consortium and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Bucks & Montgomery School Consortium has determined that the prescription drug coverage offered by the Bucks & Montgomery School Consortium Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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 a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of

the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Bucks & Montgomery School Consortium Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Bucks & Montgomery School Consortium Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Bucks & Montgomery School Consortium Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Bucks & Montgomery School Consortium prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call. **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 Bucks & Montgomery School Consortium 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 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 whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2023
Name of Entity/Sender:	Consortium Chair and Vice Chair

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES
BUCKS & MONTGOMERY SCHOOL CONSORTIUM
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

***Bucks & Montgomery School Consortium**

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Bucks & Montgomery School Consortium that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's

important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Bucks & Montgomery School Consortium) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the

case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices
If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach
Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint
If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Consortium Chair and Vice Chair

Effective Date
The effective date of this notice is: July 1, 2023.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

BUCKS & MONTGOMERY SCHOOL CONSORTIUM EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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.

To request special enrollment or obtain more information, contact:

Consortium Chair and Vice Chair

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Consortium Chair and Vice Chair

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

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Bucks & Montgomery School Consortium Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Bucks & Montgomery School Consortium Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, 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 Bucks & Montgomery School Consortium Employee Health Care Plan.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Bucks & Montgomery School Consortium Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Bucks & Montgomery School Consortium Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact your Plan Administrator:

Consortium Chair and Vice Chair

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Consortium Chair and Vice Chair.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Final notes

This summary of benefits is not intended to be a complete description of Bucks and Montgomery County Schools Healthcare Consortium's insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document rather than by this or any other summary of the insurance benefits provided by the plan.

In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although Bucks and Montgomery County Schools Healthcare Consortium maintains its benefit plans on an ongoing basis, Bucks and Montgomery County Schools Healthcare Consortium reserves the right to terminate or amend each plan in its entirety or in any part at any time.

Please contact the HR department of your participating entity with questions regarding the information provided in this overview.

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

BMCS
Health Care Consortium