HELPING YOU UNDERSTAND
Your Benefit Choices

2023

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employers benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

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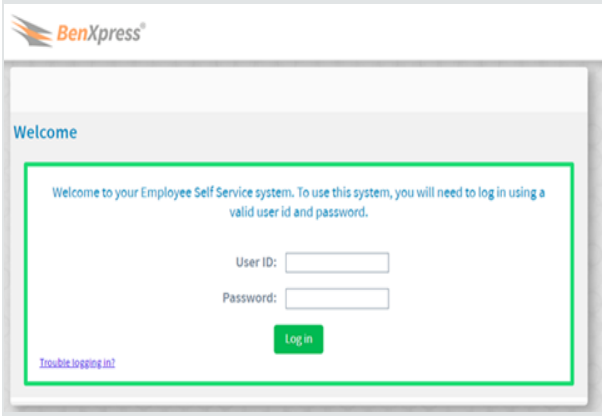
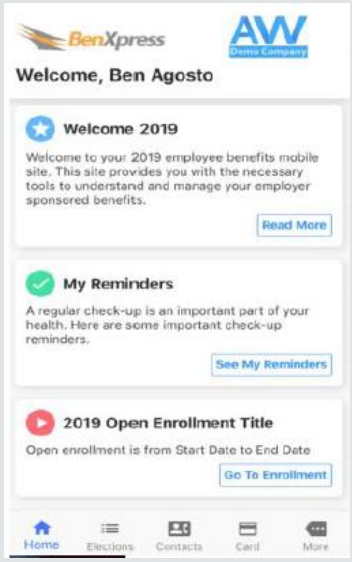
ONLINE ENROLLMENT

BENXPRESS

ONLINE ENROLLMENT THROUGH BENXPRESS





You have access to our online benefits enrollment platform 24/7 where you can enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ **Accessible 24/7;**
- ✓ **View all benefit plan options and your elections;**
- ✓ **View important carrier forms and links;**
- ✓ **Report a qualifying life event; and**
- ✓ **Make changes to beneficiary designations and more.**

ENROLLMENT INSTRUCTIONS:

1. Go to **https://www.benxpress.com/summit_regional**
2. ***Username***: First initial and last name (ex., John Smith login: jsmith)
    1. If you have a hyphenated last name, your Username will exclude the hyphen (ex., Jane William-Smith = jwilliamsmith**.**
    2. If you have a name suffix, your Username should be entered excluding the suffix (ex., John Smith Jr. = jsmith)
3. ***Password:*** Last 4 digits of your Social Security Number
4. System tips:
    1. Turn off your Pop-Up blocker
    2. The program works best in Mozilla Firefox
    3. Use the **blue** navigation arrows at the top of each screen and not the browser back arrows
    4. Once you have reviewed your Summary Screen and confirmed your benefit elections, click on the 'SAVE ELECTIONS' icon in the top right corner.
5. Follow instructions and enroll in your benefits
6. Make sure to save your elections and print your confirmation statement.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible for group health benefits on the 1st day of the month following date of hire. Eligible employees may enroll their dependents for coverage(s) as well.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;*
- A stepchild;*
- A legally adopted child;*
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner;* or
- Disabled dependents may be eligible if requirements set by the plan are met.

**Coverage ends at the end of month of 26th birthday*

COORDINATION OF SPOUSAL BENEFITS

Where a spouse is able to obtain health insurance coverage through their employer, the spouse will be required to obtain coverage through their employer unless the spouse pays more than $150.00 per month for available coverage. The spouse's plan will be treated as the primary plan for the spouse and the District's plan will be secondary.

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Laurie Litten and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Laurie Litten, Assistant Treasurer/Benefit within 30 days of the event. ***Laurie can be reached at (330) 753-1025, ext.. 13112 or*** email her at **Llitten@barbertonschools.org**.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

Your plan has an Embedded deductible. One individual must meet the single deductible. A combination of two or more members can meet a family deductible.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

OUT-OF-NETWORK charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance.

Prescription Drugs

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay.

TIER 4 | Highest specialty copay: These drugs have the highest copay usually because there may be a more cost-effective generic or preferred brand available.

Make sure to check for mail order discounts that may be available.

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an Anthem In-Network Provider?

In-Network providers can be found on your provider's website Anthem.com under "Find a Doctor" and choose the Blue Access PPO Network.

MEDICAL – Anthem Blue Cross Blue Shield

HEALTH | **BASE** PLAN COMPARISON

Each time you need medical care, you choose the provider you wish to see. The level of coverage is based on whether or not that provider is in the network. If the provider is In-Network, there is a higher level of coverage and lower costs to you. If the provider is Out-of-Network, there is a lower level of coverage which results in higher costs to you. Care and treatment by a provider who is NOT an Anthem provider may balance bill you for any amount the provider charges above the Anthem Reasonable and Customary charges. Visit **www.anthem.com** to find a network provider.

	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
DEDUCTIBLE		
Single Deductible	$1,000	$2,000
Two Person/Family Deductible	$2,000	$4,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	20%	30%
Single Maximum	$2,250	$4,500
Two Person/Family Maximum	$4,500	$9,000
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$20 copay	30% after deductible
Specialist - Office Visit	$30 copay	30% after deductible
Urgent Care Facility	$35 copay	30% after deductible
Virtual Online Visit (Specialist)	$20 copay	30% after deductible
Emergency Room Visit	$150 copay, then 10%	
OUT-OF-POCKET (OOP) MAXIMUM Pharmacy		
Single Maximum	$6,450	
Two Person/Family Maximum	$12,900	

Your Care Options and When to Use Them.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS

Rx | IngenioRx

What is Step Therapy and Prior Authorization?

Step therapy is a program that helps you and your doctor choose drugs that are right for you. After studying many drugs, Anthem's chosen certain ones to be the first drugs to try when treating some conditions. Trying drugs in a step-by-step way is called *Step Therapy*. When your doctor prescribes a drug that requires *step therapy*, a message is sent to your pharmacy's computer. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

For most people, the new drug works well.

But if it isn't right for you, your doctor can request that Anthem cover the first drug. Requesting approval is called *Prior Authorization*. Here's how it works:

First, Anthem will need to know a little more about your health. Your doctor calls or faxes information to Anthem.

- If the information meets your plan's requirements, the claim is approved. Your doctor or pharmacist lets you know the prescription can be filled.
- If Anthem needs more information, they may contact your doctor.
- If the claim is denied, you and your doctor will receive a letter explaining how to appeal it.

Mail Order

(1) A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) retail copays (one for each 30-day fill) will apply.

To set up mail order, start with setting up your payments. Select **Complete your Profile and Communications Preference** from your personal pharmacy page, then **View Pharmacy Payment Methods** and choose how you'd like to pay.

Next, send in your prescription. Your doctor's office can do this, or you can manually submit. Complete the Home Delivery Order Form found in the form's library on Anthem.com and submit to the address shown. Be sure to include your payment & prescription information.

You may also want to ask your doctor for a 30-day retail prescription to make sure you have enough medicine to last until you get your first home delivery prescription.

Rx Copays	Base Plan (30-day retail fill) (1)	Base Plan (90-day mail order)	MEC
TIER 1	$10	$20	30% After Deductible
TIER 2	$40	$80	30% After Deductible
TIER 3	$60	$120	30% After Deductible
TIER 4	50% with $200 max	50% with $200 max	30% After Deductible

WHERE CAN I FIND A DRUG LIST?

A full listing of covered drugs is found on your provider's website at Drug List Selection (anthem.com). When you go to the link, scroll down to the Formulary / Drug Lists, and Barberton City Schools is on the National Drug 4-Tier list.

At the National Drug list, select 4-Tier (Searchable) and enter the name of the medication or alphabetical search or Therapeutic Class Search. When you enter the name of the medication, you can determine what tier the medication falls under and if there are any applicable pharmacy edits such as step-therapy, prior authorizations, quantity limits and clinical criteria.

Or, if you want to download the drug list that is current at that point and time, you can click on Anthem Blue Cross and Blue Shield PDF for the National Drug List 4-Tier.

PLEASE NOTE: this is a 'live' list at that point in time and there are formulary changes throughout the year. You should always pull the most updated formulary from the site vs. reviewing a saved pdf.

++Formulary changes, deletions occur twice a year, October & April. Additions and clinical edits may happen throughout the year++

A drug list, also called a formulary, is a list of generic and brand-name drugs covered by a health plan. Although a drug may be on the drug list, it might not be covered under every plan. Review the plan materials for details on specific benefits.

You can use drug lists to see if a medication is covered by your health insurance plan. You can also find out if the medication is available as a generic, needs prior authorization, has quantity limits and more.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

MEDICAL – Anthem Blue Cross Blue Shield

HEALTH | **MEC (Minimum Essential Coverage)** PLAN COMPARISON

Barberton City Schools offers a Minimum Essential Coverage (MEC) Bronze plan that meets the Affordable Care Act requirements for having health coverage. This plan option is offered to all eligible employees that work an average of 30 hours per week. ***This plan is a high deductible plan and you will need to meet (pay the providers) the deductible ($6,000 or $12,000) BEFORE Anthem pays anything.***

	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
DEDUCTIBLE		
Single Deductible	$6,000	$10,000
Two Person/Family Deductible	$12,000	$20,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	100%	50%
Single Maximum	$6,350	$15,000
Two Person/Family Maximum	$12,700	$30,000
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	100% after deductible	50% after deductible
Virtual Visit with First Stop Health	$0 copay	N/A
Specialist - Office Visit	100% after deductible	50% after deductible
Urgent Care Facility	100% after deductible	50% after deductible
Emergency Room Visit	100% after deductible	50% after deductible
OUT-OF-POCKET (OOP) MAXIMUM		
Single Maximum	$6,350	
Two Person/Family Maximum	$12,700	

Your Care Options and When to Use Them.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

TELEMEDICINE

24/7 **| First Stop Health**
VIRTUAL DOCTOR VISITS

DOWNLOAD THE APP

Get the information you need on the go by downloading the First Stop Health App from the App Store for Apple℠ products or on the Google Play™ Store for Android products.

Download on the App Store

GET IT ON Google Play

Employees on the medical plan and their covered dependents will have 24/7/365 access to doctors. Through First Stop Health membership, they can simply call 888-691-7867 and begin speaking with a doctor who can diagnose and treat common illnesses (e.g., sinus issues, pink eye, etc.) over the phone. There are no fees or copays to use this telemedicine benefit. There is no setup or pre-registration necessary!

Call 888-691-7867 to speak to a physician

What to Expect:

- Available 24/7/365
- Unlimited consultations
- U.S.-based physicians
- Physicians licensed in 49 states (AR excluded)
- No copays or fees to use the service
- 86% of calls to First Stop Health prevent unnecessary trips to doctors' offices and ERs
- Includes covered dependents
- Confidential medical dashboard with record of consultations + tools to upload and share medical records

"I used First Stop Health and it is terrific. I'm at the airport now, leaving for my honeymoon with prescription in hand. Lifesaver!"
–Laura S., First Stop Health Member

Top 10 Reasons Members Call First Stop Health

1	Sore Throat
2	Cough
3	Sinus Infection
4	Urinary Tract Infection
5	Skin Rash
6	Eye Infection
7	Ear Ache
8	Upset Stomach
9	Muscle/Joint Pain
10	Medication Refill

To learn more about First Stop Health telemedicine services, contact:

www.fshealth.com
888.691.7867

222 N. Columbus Dr., Suite D
Chicago, IL 60601

FSH first stop health

WELLNESS RESOURCE

Be Well Solution

The Barberton City School's Wellness program is a voluntary program available to all employees. Be Well Solutions consists of activities that are designed to increase awareness, assess risk, educate and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing injury and illness.

Employees who voluntarily participate in the wellness program will have the opportunity to earn Deductible Credits. Deductible Credits are defined as discounted units to be applied directly against the major medical plan deductible. The Deductible Credits are based on the scores from the prior year's biometric screening.

Categories	Target	Deductible Credit (single)	Deductible Credit (family)
Annual Physical	Complete	$100	$200
Tobacco User	Must be non-smoker or participate in smoking cessation program	$100	$200
LDL/HDL Cholesterol	≤ 240	$100	$200
BMI	≤ 30	$100	$200
Blood Pressure	140/90 or less	$100	$200

Take advantage of all that Be Well Solutions has to offer, many of the services are available online at www.portal.bewelldata.com. Services include:

- Registered Dietician Consults
- Personal Health Coaching
- Web Based and Individualized Resources
- Wellness Education Materials
- Onsite Screenings and Flu Shot Clinics

Questions? ***Contact Be Well Solutions at (888) WEL-SERV or info@bewellsolutions.com***

DENTAL

Delta Dental COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

You have the freedom to select the dentist of your choice; however, when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

How do I find an In-Network Provider:

These plans offer deeper discounts when you visit a provider that is In-Network. You have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. These two networks provide superior access to care as well as reduced fees through their agreements with participating dentists.

To find a Delta Dental dentist, go to **DeltaDentalOH.com/findadentist** or call (800) 524-0149.

	PPO Network	Premier Network	Out-of-Network
PLAN FEATURES			
Network Details	**Delta Dental** Network	**Premier** Network	Dentists who do not participate in either network.
Benefit Period	**Calendar Year**		
DEDUCTIBLE			
Single	**$25** In-network **/ $25** out of network		
Two Person	**$50** In-network **/ $50** out of network		
Family	**$50** In-network **/ $50** out of network		
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)		
COVERED SERVICES			
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments*	**Covered at 100%**	**Covered at 100%**	**Covered at 100% of UCR** *With possible balance billing*
CLASS II: Basic Services *Emergency Palliative treatment, minor restorative services, endodontic (root canals), periodontic (gum disease), oral surgery services*	**Covered at 80%**	**Covered at 80%**	**Covered at 80% of UCR** *With possible balance billing*
CLASS III: Major Services *Prosthodontics, crowns, inlays/onlays, dentures, implants & bridges*	**Covered at 60%**	**Covered at 60%**	**Covered at 60% of UCR** *With possible balance billing*
CLASS IV: Ortho Services **Lifetime Benefit $1,500 **Up to age 19*	**Covered at 50%**	**Covered at 50%**	**Covered at 50% of UCR** *With possible balance billing*
ANNUAL MAXIMUM			
Maximum Benefit *Allowed per Benefit Period*	**$2,500 per covered individual**		

VISION

VSP COVERAGE OVERVIEW

Your enhanced vision benefit through **VSP (Vision Service Plan)** is outlined below. Services rendered with a participating **VSP CHOICE network** provider will be paid at a higher level. To find a VSP Choice doctor, visit www.vsp.com or call 1-800-877-7195. When you see a VSP Choice doctor, you'll get the most out of your benefit and have lower out-of-pocket costs.

Reminder: Your dependent children are eligible until the end of the month in which they attain the age of 26, regardless of student status.

Your VSP Vision Benefits Summary

Barberton City Schools and VSP provide you with an affordable eyecare plan.

vsp Vision care for life

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$20 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $55	Every 12 months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
Your Coverage with Out-of-Network Providers			
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.			

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.vsp.com/find-eye-doctors

Search by location, doctor name, or office name.

FLEXIBLE SPENDING ACCOUNT

FSA | American Benefits Group (ABG)

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov.**
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.**fsastore.com.**

HEALTH CARE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,050

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$5,000** annually in pre-tax dollars, or **$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Barberton City School's Health Care FSA has a rollover feature. It allows any amount remaining in your account at the end of the plan year to roll over into the new plan year.

This only applies to the Health Care FSA.

Check your account balances at **www.amben.com**

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**ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:*

1. **'Care'** for your dependent child who is under the age of 14 (formerly up to age 13) that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

HERE'S HOW IT WORKS

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $110.42 based on a 24-pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $574.

	Without FSA	With FSA
Gross Income	$30,000	$30,000
FSA Contributions	$0	-$2,650
TAXABLE INCOME	**$30,000**	**$27,350**
Estimated Taxes		
Federal	**$3,090***	**-$2,817***
State	**$1,104****	**$1,106****
FICA	**$2,295**	**$2,092**
AFTER TAX EARNINGS	**$23,511**	**$21,435**
Eligible Out-Of-Pocket Expenses	$2,650	$0
AVAILABLE/SPENDABLE INCOME	**$20,861**	**$21,435**

That's a savings of $574 for the year!

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

**Varies, assumes 10.30%;*
***Varies, assumes 3.68%*

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Health Care Reform legislation requires that certain over-the-counter (OTC) items require a "prescription" in order to be considered an eligible Health Care FSA expense. You will need to obtain a prescription for the 2020 and 2021 plan year.

You can continue to purchase your regular prescription medications with your debit card. However, the debit card may not be used as payment for an OTC item, even when accompanied by a prescription.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eyeglasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at **www.FSAstore.com,** where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses* out-of-pocket*, you can submit an FSA claim form along with your original receipts for reimbursement.

BOARD PAID LIFE & VOLUNTARY EMPLOYEE PAID LIFE
ANTHEM COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction. Updates to your beneficiary can be done anytime on BenXpress.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BOARD PAID LIFE/AD&D INSURANCE

All eligible employees are automatically enrolled with Board paid life and AD&D with Anthem.

Life insurance is an important part of your financial security. It helps protect your family from financial risk and sudden loss of income in the event of your death.

AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

VOLUNTARY LIFE (EMPLOYEE PAID) LIFE

During the new hire enrollment period, employees have the opportunity to purchase voluntary life insurance up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI).

· You may select life coverage for yourself in increments of $5,000 up to $500,000 not to exceed 5 times your earnings. Guarantee issue is $150,000.

· You may select life coverage for your spouse in increments of $5,000 up to $250,000. Guarantee issue is $75,000. Spouse rates are based on the employee's age.

· You may purchase life coverage for your dependent child(ren) in increments of $2,500 up to $20,000 for each child up to age 26.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

EMPLOYEE ASSISTANCE PROGRAM

Anthem EAP COVERAGE OVERVIEW

Visit www.anthemEAP.com and login with CFCSD for more information

Employee Assistance Program
Service Summary
Barberton City Schools District

Anthem EAP

Available 24/7, 365 days a year

Everything you share is confidential*

Life can be full of challenges. Your Employee Assistance Program (EAP) is here to help you and your household members.
EAP offers a wide range of **no-cost** support services and resources, including:

Counseling
- Up to 4 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services

Legal consultation
- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online

Financial consultation
- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online

ID recovery
- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations

Emotional Well-being Resources
- Digital tools to improve emotional well-being
- Team up with an experienced clinical coach
- Practice mindfulness on the go

Dependent care and daily living resources
- Online information about child care, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

Other anthemEAP.com resources
- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

Crisis consultation
- Toll-free emergency number; 24/7 support
- Online critical event support during crises

We are ready to support you

You can call us at **800-865-1044**, or go to **anthemEAP.com** and enter your company code: Barberton

IMPORTANT CONTACT INFORMATION

CARRIER	CONTACT INFORMATION
Anthem Blue Cross Blue Shield	(800) 552-9159 www.Anthem.com
IngenioRx	(833) 248-1439 www.Anthem.com
Delta Dental	(800) 524-0149 www.deltadentaloh.com
VSP Vision	(800) 877-7195 www.vsp.com
Be Well Solutions	(888) 935-7378 info@bewellsolutions.com www.bewellsolutions.com
American Benefits Group (ABG) **Flexible Spending Accounts**	(800) 499-3539 support@amben.com www.amben.com
First Stop Health **Telemedicine**	(888) 691-7867 Member_Services@fshealth.com www.fshealth.com
AFSCME Dental, Vision & Hearing	(216) 781-6420 www.AFSCMECarePlan.com

Have Questions?

Please see the chart above for provider customer service phone numbers and website addresses.

Your first point of contact for claims should be to the carrier's Customer Service numbers - shown above.

For issues which require additional assistance, you may also contact our Account Management Team at NFP Corporate Services (OH) Inc.:

Dawn Tremmel, NFP Senior Benefit Coordinator, Phone: (216) 273-8550 or E-mail: dawn.tremmel@nfp.com

Nancy Petel, NFP Senior Account Executive, Phone: (216) 264-2726 or E-mail: Nancy.Petel@nfp.com

This Benefit Enrollment Guide Is Provided By:

NFP