MONROE PUBLIC SCHOOLS

MONROE, CONNECTICUT

Employee Benefit Booklet 2023/2024

Every effort has been made to ensure the accuracy of the information in this Employment Benefit Guide. Plan provisions summarized in this overview contain only highlights. If there is a discrepancy between this overview and the plan documents, the plan documents will govern. The following descriptions of available benefit elections options are purely informational and have been provided to you for illustrative purposes only.

Welcome

To Our Valued Employees:

Welcome to Open Enrollment for 2023 - 2024

There is no doubt that healthcare costs continue to increase. Monroe Public Schools is dedicated to making sure that the plans available to you offer the best benefits possible while keeping costs reasonable.

Open enrollment provides you and your eligible dependents with the opportunity to review the benefit package being offered to you and allows you to make clear and informed decisions about your plan. This guide will help you to navigate the plan design choices and choose the benefit programs that make the most sense for you.

We offer the following employee benefits:

- Medical & Prescription Drug Insurance
- Flexible Spending Account (FSA)
- Limited Flexible Spending Account (LFSA)
- Dependent Care Account (DCA)
- Dental Insurance
- Vision Insurance
- Employer Paid Life and AD&D Insurance

Online Enrollment for your benefit selections via Munis Employee Self Service (ESS), Benefits Section

This open enrollment you will be using Munis Employee Self Service (ESS), Benefits Section. Munis Employee Self Service (ESS), Benefits Section is Monroe's self-service web site where you will be making your annual benefit elections for 2023 - 2024. Human Resources will provide you with instructions for getting started with selecting your benefits via Munis Employee Self Service (ESS), Benefits Section.

IMPORTANT: All benefit eligible employees are required to make your 2023 - 2024 benefit selections using Munis Employee Self Service (ESS), Benefits Section.

Table of Contents

Monroe BOE offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs. Enclosed you will find detailed summaries of the benefits offered by Monroe BOE for the 2023 – 2024 plan year.

After you have enrolled in insurance coverage, you may receive additional information in the mail from the insurance carriers. Please use this booklet as a guide to your benefits and review all carrier documents for the most comprehensive descriptions of all your offered lines of coverage.

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Benefit Plan Overview

	What Benefits are Offered?	How to Make Elections:
Medical, Rx and Vision Coverage **United HealthCare**	• A low - / no- deductible Point of Service (POS) plan. • $15 co pay in network office visits. • Free preventive care • $0 co-pay for Preferred Providers • $5 or $10/$25/$40 Prescription Co-Payments. • Vision coverage is included in the plan.	You will be making your medical plan elections online using Munis Employee Self Service (ESS), Benefits Section.
Dental Coverage **Cigna**	Cigna PPO	You will be making your dental elections online using Munis Employee Self Service (ESS), Benefits Section.
Basic Life and AD&D **Anthem**	Our Basic Life and AD&D coverage is provided to eligible employees at no cost.	Eligible employees are automatically enrolled. You may update your beneficiary information via the online enrollment tool, Munis Employee Self Service (ESS), Benefits Section.
Flexible Spending Account (FSA), Limited Flexible Spending Account (LFSA) and Dependent Care	Our FSA, and DCA are administered by Benefit Strategies. For the FSA you may elect up to $3,050. For the DCA, you may elect up to $5,000.	You will make your FSA/ DCA elections using Munis Employee Self Service (ESS), Benefits Section.

NOTE:

- All benefit-eligible employees are eligible to participate in a Flexible Spending Account (FSA).
- All benefit-eligible employees are eligible to participate in the Dependent Care Account (DCA).

Enrollment and Eligibility

Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "Qualifying Event."

Whom can you add to your plan?

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption
- Common law spouse, only if your company covers domestic partners

Qualifying Event

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must submit your paperwork **within 30 days** of the change or you will be considered a late enrollee and have to wait until yearly open enrollment on June 30, 2021. Examples of a qualifying event:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage

COBRA

If one of the following events should occur, you or your eligible dependents are eligible for continuation of coverage under Federal and/or State COBRA regulations:

- Voluntary Termination
- Involuntary Termination (Gross Misconduct Exception)
- Reduction of hours as a result of a layoff or leave of absence
- Death of the Employee
- An Employee's Medicare Entitlement
- Divorce or Legal Separation
- Dependent becomes ineligible

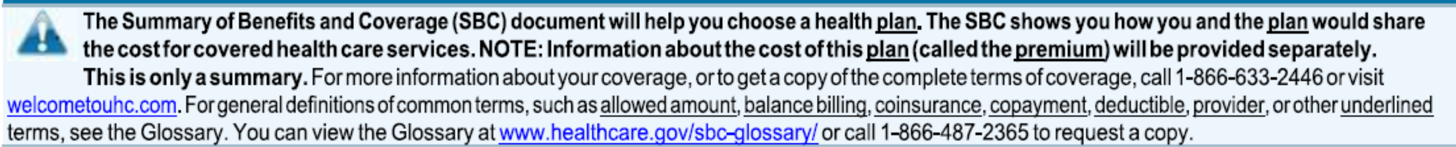
Qualified Beneficiary Rights

A qualified beneficiary is entitled to the same rights under the group benefit plans as a "similarly situated active employee." An employee's covered spouse (or dependent) has the same rights under the plan as the active employee once the COBRA qualifying event occurs.

It is your responsibility to notify the Human Resources Department of the qualifying event within sixty (60) days. You are also responsible to keep the Human Resources Department informed of changes in your address, as well as address changes for your dependent(s), if different from your own. If you want more information about your rights and responsibilities under COBRA, please contact Human Resources.

Choice Plus CR9W Mod / 200 Mod

Coverage For: Family | Plan Type: PS1



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$0** Out-of-Network: **$300** Individual / **$900** Family Per policy year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$2,000** Individual / **$4,000** Family Out-of-Network: **$2,000** Individual / **$4,000** Family Per policy year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-866-633-2446 for a list of network providers.	You will pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Designated Network: No Charge Network: $15 copay per visit, deductible does not apply	20% coinsurance	Virtual Visits - No Charge by a Designated Virtual Network Provider. Any other Telehealth service is subject to costshare based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: No Charge Network: $15 copay per visit, deductible does not apply	20% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: Designated Network: No Charge Network: 20% coinsurance, deductible does not apply X-Ray/Diagnostics: No Charge	20% coinsurance	Preauthorization is required out-of-network for certain services. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider.
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	Preauthorization is required out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $5 copay, deductible does not apply. Mail-Order: $5 copay, deductible does not apply.	Retail: $5 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 90 day supply. Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Out-of-Pocket Limit: $4,600 Ind/ $9,200 Fam.
	Tier 2 - Your Mid-Range Cost Option	Retail: $25 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Retail: $25 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $40 copay, deductible does not apply. Mail-Order: $40 copay, deductible does not apply.	Retail: $40 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	Preauthorization is required out-of-network for certain services.
	Physician/ surgeon fees	No Charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent Care	$15 copay per visit, deductible does not apply	20% coinsurance	Virtual Visits - No Charge by a Designated Virtual Network Provider. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization is required out-of-network.
	Physician/ surgeon fees	No Charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit, deductible does not apply	20% coinsurance	Network Partial hospitalization/intensive outpatient treatment: No Charge Preauthorization is required out-of-network for certain services. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	No Charge	20% coinsurance	Preauthorization is required out-of-network. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	20% coinsurance	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	20% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No Charge	20% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance, deductible does not apply	Limited to 200 visits per policy year. Preauthorization is required out-of-network.
	Rehabilitation services	No Charge	20% coinsurance	In-network: Outpatient rehabilitation services are unlimited per policy year. Out-of-Network: Limits per policy year: Physical: 30 visits; Occupational: 30 visits; Speech: 30 visits; Cardiac and Pulmonary: unlimited.
	Habilitative services	No Charge	20% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	No Charge	20% coinsurance	Out-of-Network: Inpatient Skilled nursing limited to 60 days per policy year. Out-of-Network: Inpatient rehabilitation and inpatient habilitative limited to 60 days per policy year. Preauthorization is required out-of-network.
	Durable medical equipment	No Charge	20% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000.
	Hospice services	No Charge	20% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance	Limited to 1 exam per policy year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Glasses
- Long Term Care
- Non-emergency care when traveling outside - the US
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits per policy year
- Bariatric surgery
- Chiropractic (manipulative care)-Network unlimited. Out-of-network- 30 visits per policy year.
- Hearing aids
- Infertility Treatment
- Outpatient private duty nursing
- Routine Eye Care - 1 Exam per policy year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Connecticut Insurance Department at 1-800-203-3447 or 1-860-297-3900 or ct.gov/cid/site/default.asp.
Additionally, a consumer assistance program may help you file your appeal. Contact Connecticut Insurance Department at 1-800-203-3447 or 1-860-297-3900 or ct.gov/cid/site/default.asp.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** — $0
- **Specialist copay** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other coinsurance** — 0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$70

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** — $0
- **Specialist copay** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other coinsurance** — 0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$600

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** — $0
- **Specialist copay** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other coinsurance** — 0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$300

The plan would be responsible for the other costs of these EXAMPLE covered services.

Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care**—you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

United Healthcare

Activation is quick

1. Go to **myuhc.com > Register Now**

2. Fill out the required fields and create your username/password

3. Enter your contact information and security questions

4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

Get started at myuhc.com

United Healthcare

[1] UnitedHealthcare Internal Claims Analysis, 2019.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

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Get on-the-go access to your health plan.

The UnitedHealthcare® app puts your plan at your fingertips.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.*
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.

Get the app and log on with Touch ID®.

The UnitedHealthcare app is available for download for iPhone® or Android®.

United Healthcare

*Data rates may apply.

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SEARCHING FOR PROVIDERS WITH UNITED HEALTHCARE

Even if you're not an active member, you can still search for providers or pull up listings of providers (physicians, hospitals, labs, radiology, etc.) by using UHC's member portal www.myuhc.com or if you are looking for a behavioral health provider the www.liveandworkwell.com site.

Here are the steps to follow to look up a medical provider:

1. Go onto www.myuhc.com
2. Click on Find a Provider (You will see an option to sigh in and register, you do not need to do that in order to use the provider search function.)
3. Click on Medical directory
4. Click on Employer and Individual Plans
5. Click on Shopping Around
6. Click on Choice Plus
7. Enter the location (zip code, city & zip code, etc.) that you are looking for providers in and click Continue
8. Click the appropriate category that you would like to search by (people, places, services and treatments or care by condition) or if you know the specific provider or facility name you can type that in the search box.
9. Click the appropriate care you are looking for (primary, specialty, etc.) and the type of provider you want.
10. This will give you a list of providers in that given area which can be printed or emailed.
11. Providers with the two blue heart designation shows a premium care physician that would be a $0 copay.

To search for Behavioral health providers:

1. Go onto www.liveandworkwell.com
2. Click on "Browse as a guest with a company access code and enter **UHC** for the code and hit Enter
3. Click on the provider directory box or on the top bar click on "Find Care" and then "Provider"
4. Enter the City and State you would like to search or if you have the name of the provider it can be entered
5. Click Search
6. You can then filter by gender, languages, license type, provider type, are of expertise, etc.

Medical Accounts
Flexible Spending Account

What is a Flexible Spending Account – FSA?

Flexible spending accounts, or FSAs, provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income. Essentially, the Internal Revenue Service (IRS) set up FSAs as a means to provide a tax break to employees and their employers. As an employee, you agree to set aside a portion of your pretax salary in an account, and that money is deducted from your paycheck over the course of the year

The FSA "Year" Corresponds to the "Plan Year". How Does It Work?

- Regular amounts are deducted from your gross wages and credited to your spending account.
- Payments are issued to you and debited from your spending account when you submit a documented claim for reimbursement.
- The maximum annual elections for the current plan year is **$3,050**. Your entire Health Care FSA election is available to you at any time. You do not have to have contributed the money you wish to claim. However, your Dependent Care FSA election is only available in the amount that you have contributed up to the date that you file a claim.
- **Rollover*****: You may rollover up to $610 in unused FSA dollars into the next year.***

To set up a spending account, you will need to do the following:

Estimate how much money you spend for out-of-pocket healthcare and/or dependent day care expenses each year. Complete an enrollment form during your open enrollment period and submit to your HR.

Can I take my FSA with me if I change jobs?

Under the federal act known as COBRA, you have the option to continue participating in your employer's health care FSA. If you choose to continue a health care FSA under COBRA, your contributions must be paid with after-tax dollars. You cannot continue in a dependent care FSA under COBRA.

Dependent Care Account

What is a Dependent Care Account?
A Dependent Care Account is a pre-tax benefit account used to pay qualified out-of-pocket dependent care expenses for eligible dependents under age 13.

HEALTH CARE (or LIMITED PURPOSE) ACCOUNT	DEPENDENT CARE ACCOUNT
You can set aside pre-tax dollars to pay for health care expenses not covered under the medical, dental or vision plan. Items such as over-the-counter medication (with prescription), contact lens solution, and prescription sunglasses, are all covered. (Note: A Limited Purpose Account only covers dental and vision plan expenses. Available to employees who have an open HSA Bank account.)	You can set aside pre-tax dollars to pay for dependent care expenses, such as a child's day care, extended care, after school or assistance for an elderly parent or incapacitated dependent. Proof of payment is required by the IRS so make sure that you have a printed receipt for all of your services.
Sample List of Regular FSA Eligible Expenses: Doctor visit co-payments, Prescription drugs co-payments, Hospital co-insurance, Dental co-payments, Contact Lenses, Prescription Sunglasses.	**Sample of Eligible Expenses for Children:** Nanny, Babysitter, Housekeeper, Pre-K, Before and after school care through age 12. Expenses paid to a relative are also eligible as long as they are age 19+ and are not a tax dependent of the FSA participant.
Maximum Contribution Allowed: **$3,050**	**Maximum Contribution Allowed:** **$5,000**

Dental Plan

Monroe BOE offers you and your eligible dependents the opportunity to enroll in dental coverage with Cigna PPO. Should there be a discrepancy between the table and the plan documents, the plan documents will govern.

Cigna	PPO	
Calendar Year Deductible	**In Network**	**Out of Network**
▪ Individual ▪ Family	**$25** **$50**	
Preventive Care ▪ Oral Examinations & Cleanings (Twice a year) ▪ Diagnostic X-rays ▪ Simple Extractions ▪ Fillings ▪ Fluoride Treatments (1 per year Up to Age 19)	100% Deductible Waived	100% Deductible Waived
Basic Services ▪ Oral Surgery ▪ General Anesthesia (some exclusions apply) ▪ Endodontics ▪ Periodontics	85% After Deductible	85% After Deductible
Major Services ▪ Crowns ▪ Bridges ▪ Dentures	50% After Deductible	50% After Deductible
Calendar Year Benefit Maximum	Please refer to your bargaining unit contract for specifics	
Orthodontia Services	50% to $1,000 lifetime max per	

**Please refer to the Cigna plan document for details of the covered benefits.*

*****Dependent coverage to the end of the plan year the dependent turns age 26***

Other Benefits -
Basic Life and AD&D / Long Term Disability

Life insurance isn't a fun thing to think about, and it may seem like an unnecessary expense. But if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you – your designated beneficiary would collect a financial benefit upon your death.

Basic life and Accidental Death & Dismemberment (AD&D) is provided through Anthem. Monroe BOE's Long Term Disability (LTD) is provided through Anthem. This coverage is an important coverage for financial protection in the event your disability continues beyond short-term disability.

Monroe BOE provides all full-time employees with basic life and AD&D coverage at NO cost to you!

Basic Life and AD&D Insurance - Anthem	
Employee Life/AD&D Schedule	Administrators: 1.5 times salary Custodians: $50,000 Flat Information Technology: $50,000 Flat Librarians: $50,000 Flat Nurses: $50,000 Flat Paraprofessionals 20-30 Hours: $25,000 Flat Paraprofessionals 30+ Hours: $49,999 Flat Secretaries 10 Month: $50,000 Flat Secretaries 12 Month: $50,000 Flat Teachers: 1 times salary to $100,000 Unaffiliated: $50,000 Flat
Age Reduction	Varies by unit, please consult the plan certificate for details.
Long Term Disability Plan	
Elimination Period is 90 Days	Administrators: 66. 67% of basic monthly earnings. Custodians: 60% of basic monthly earnings up to $5,000/month. Information Tech: 60% of basic monthly earnings up to $2,000/month. Librarians: 60% of basic monthly earnings up to $2,000/month. Nurses: 60% of basic monthly earnings up to $5,000/month. Paraprofessionals 20-30 Hours: 60% of basic monthly earnings up to $1,200/month. Paraprofessionals 30+ Hours: 60% of basic monthly earnings up to $1,200/month. Secretaries 10 Month: 60% of basic monthly earnings up to $5,000/month. Secretaries 12 Month: 60% of basic monthly earnings up to $5,000/month.

Please refer to the Insurance Plan Certificate for the details of your coverage including limitations and exclusions.

Payroll Deductions – 7/1/2023 – 6/30/2024

When choosing your medical plan, consider the following:

- What are your anticipated medical expenses for the coming year?
- How much will you have to pay for these expenses in terms of copayments and coinsurance?
- Do you have any other sources of medical insurance coverage?
- Do you have a preferred physician and are they in the corresponding carrier's network of providers?
- How much can you afford to pay towards the cost of your coverage?

Unit	Number of Pay Periods	Medical Payroll Contribution	Dental Payroll Contribution	Total Medical & Dental Payroll Contribution
Teachers				
Employee Only	20	$151.18	$6.61	$157.79
Employee Plus One		$324.01	$13.03	$337.04
Employee Plus Family		$396.03	$24.07	$420.09
Administrators				
Employee Only	24	$125.99	$5.04	$131.03
Employee Plus One		$270.01	$9.94	$279.95
Employee Plus Family		$330.02	$18.36	$348.38
12 Month Secretaries				
Employee Only	24	$91.90	$3.68.	$95.57
Employee Plus One		$196.95	$7.25	$204.20
Employee Plus Family		$240.72	$13.39	$254.11
10 Month Secretaries				
Employee Only	20	$110.28	$4.41	$114.69
Employee Plus One		$236.34	$8.70	$245.04
Employee Plus Family		$288.87	$16.07	$304.94
Librarians				
Employee Only	20	$115.61	$5.55	$121.17
Employee Plus One		$247.77	$9.36	$257.14
Employee Plus Family		$302.84	$16.40	$319.24
Nurses				
Employee Only	20	$117.39	$4.70	$122.09
Employee Plus One		$251.59	$9.26	$260.85
Employee Plus Family		$307.50	$17.11	$324.61
Custodians				
Employee Only	24	$90.41	$3.62	$94.03
Employee Plus One		$193.77	$7.13	$200.91
Employee Plus Family		$236.84	$13.18	$250.02
10 Month School Security Guard				
Employee Only	20	$108.50	$4.34	$112.84
Employee Plus One		$232.53	$8.56	$241.09
Employee Plus Family		$284.21	$15.81	$300.02
30-Hour Paraprofessional				
Employee Only	19	$101.10	$4.05	$105.15
Employee Plus One		$443.55	$15.69	$459.24
Employee Plus Family		$586.24	$35.72	$621.95

Unit	Number of Pay Periods	Medical Payroll Contribution	Dental Payroll Contribution	Total Medical & Dental Payroll Contribution
20-30 Hour Paraprofessional				
Employee Only	19	$254.63	$10.19	$264.82
Employee Plus One		$1,110.74	$39.31	$1,150.05
Employee Plus Family		$1,467.46	$89.37	$1,556.83
12 Month IT & Unaffiliated				
Employee Only	24	$120.06	$4.80	$124.86
Employee Plus One		$257.30	$9.47	$266.78
Employee Plus Family		$314.49	$17.50	$331.99
10 Month ASSO				
Employee Only	20	$108.50	$4.34	$112.84
Employee Plus One		$232.53	$8.56	$241.09
Employee Plus Family		$284.21	$15.81	$300.02
10 Month Unaffiliated				
Employee Only	20	$144.07	$5.77	$149.84
Employee Plus One		$308.77	$11.37	$320.13
Employee Plus Family		$377.39	$21.00	$398.39
10 Mth Unaffiliated Per Diem				
Employee Only	20	$151.18	N/A	$151.18
Employee Plus One		$324.01	N/A	$324.01
Employee Plus Family		$396.03	N/A	$396.03
10 Month MELC				
Employee Only	20	$711.46	N/A	$711.46
Employee Plus One		$1,524.77	N/A	$1,524.77
Employee Plus Family		$1,863.65	N/A	$1,863.65
12 Month MELC				
Employee Only	24	$124.50	$4.98	$129.49
Employee Plus One		$266.83	$9.82	$276.66
Employee Plus Family		$326.14	$18.15	$344.28

Required Notices

Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours are applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess for 48 hours (or 96 hours).

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

The benefits related to mastectomies changed quite a bit with the Women's Health and Cancer Rights Act (WHCRA) of 1998. This article will answer some of the common questions patients have about the WHCRA.

What does WHCRA cover?

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits, including:

- 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
- External breast forms that fit into your bra for before or during reconstruction
- Treatment of any physical complications of the mastectomy, including lymphedema

I had a mastectomy due to non-cancer related health issues. Am I covered under WHCRA?

Yes. These rights are not limited to cancer patients. If your plan covers mastectomies, WHCRA rights apply.

My job does not offer a group health plan. Does WHCRA apply to my individual health insurance policy?

Yes. WHCRA applies to group health plans that are provided by an employer or union as well as to individual health insurance policies that are not based on employment.

Your health plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits. I receive health benefits through my church. Am I still covered under WHCRA?

There are certain "church" and "governmental" plans that are not subject to this law. Generally, though, any plan that provides coverage for mastectomies must also comply with WHCRA. Check with your provider for information specific to your plan.

Will my co-pay for reconstructive surgery be more expensive than my co-pay for other health conditions?

No. If your health plan requires a co-payment for other health conditions, the co-pay for your mastectomy benefits must be the same. For example, it is a violation of WHCRA for your plan to cover 90 percent of hip replacement surgery but to only cover 70 percent of breast reconstruction.

Is my health plan required to inform me of my rights under WHCRA?

Yes. Your health plan must provide you with a notice of your rights under WHCRA when you first enroll in the health plan, and then annually after that.

COBRA

What is COBRA Continuation of Coverage?

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

Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the maximum period for which continuation coverage must be offered for the specific qualifying events and the qualified beneficiaries who are entitled to elect continuation coverage when the specific event occurs. Note that an event is a qualifying event only if it causes the qualified beneficiary to lose coverage under the plan.

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of an employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

It is the responsibility of the employee to notify the Human Resources Department of the qualifying event within sixty days.

If you would like additional information about COBRA, please contact Human Resources.

Medicare Part D

Important Notice from the Monroe Board of Education About Your Prescription Drug Coverage and Medicare

This notice may or may not apply to you and/or your dependents

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Monroe Board of Education on and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Monroe Board of Education coverage may be affected. Please see your current plan design for a description of current coverage.

If you do decide to join a Medicare drug plan and drop your current Monroe Board of Education coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Monroe Board of Education and don't join a Medicare drug plan within 63 continuous days after your current coverage

ends, you may pay a Higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Monroe Board of Education changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of
  the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is
available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov,
or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

In Connecticut, HUSKY Health encompasses Medicaid and the Children's Health Insurance Program. As administering agency, the Department of Social Services partners with Access Health CT, our state's health insurance marketplace, in HUSKY Health enrollment. HUSKY also partners with our contracted administrative services organizations and enrolled providers to coordinate medical, dental, pharmacy, behavioral health and other benefits.

HUSKY Health provides a comprehensive health care benefit package, including preventive care, primary care and specialist visits, hospital care, behavioral health services, dental services, and prescription medications.

For general information and referral, you can call 1-877-CT-HUSKY (1-877-284-8759), toll-free, Monday through Friday from 8:30 am to 6 p.m. or visit the HUSKY website at www.huskyhealth.com for additional information.

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 January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa **www.cms.hhs.gov**
1-866-444-EBSA (3272) 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.

Health Care Reform

What is the Health Care Reform law?

The Health Care Reform law, officially known as the Patient Protection and Affordable Care Act, was signed by President Obama in March of 2010. The law is intended to expand access to affordable quality health care for Americans. The law will be implemented over a 10 year period. Some things may affect you and your family while others may not.

People can choose to buy health insurance on or off state insurance exchanges. If a person cannot keep minimum essential coverage, the Internal Revenue Service will collect a tax penalty from him or her. The monthly tax penalty is described as 1/12th of the greater of:

For 2023: The penalty is reduced to zero ($0).

IMPORTANT FOR EMPLOYEES TO UNDERSTAND

What are subsidies and who is eligible?

Beginning in 2014, a Federal Premium Assistance Tax Credit was made available to eligible individuals to subsidize the cost of insurance coverage purchased through a state Exchange. Eligibility for a subsidy is based on income.

Coverage is "affordable" if no full-time employee is required to pay more than 9.66% (2016)/9.69% (2017) of his/her "household income" for self-only coverage under the employer's lowest-cost option that provides minimum value. **However, individuals who are eligible for employer sponsored coverage that is "affordable" and provides "minimum value" are not eligible for the subsidy.**

Does my employer's health coverage affect eligibility for a Premium Assistance Tax Credit?

YES, your employer's offer of health coverage to its full-time employees meets minimum value requirements and the cost of your employer's plan meets affordability requirements. **Because the health plan meets both the minimum value and affordable standards, full-time employees would not be eligible for the Federal Premium Assistance Tax Credit to purchase coverage through a state Exchange.**

What is an Exchange?

Health Insurance Marketplaces, or Exchanges, were developed as new options where people can compare and purchase standard health insurance plans. Visit www.healthcare.gov for more information. Connecticut's Marketplace is AccessHealthCT and can be accessed through www.accesshealth.com.

Taxes

How does the Healthcare Reform Law impact my personal tax reporting?

A 1095 form is similar to a W-2 form. Your employer or insurer sends one copy to the Internal Revenue Service (IRS) and one copy to you. A W-2 form reports your annual earnings. A 1095 form reports your health care coverage throughout the year. Your employer and/or Health Insurance Company should send one to you either by mail or in person. They may send the form to you electronically if you gave them permission to do so.

You should have received it each year by January 31, just like your W-2.

Form 1095-C Employer Provided Health Insurance Coverage and Offer

- The Form 1095-C will include information about the health insurance coverage offered to you (and your spouse and dependents) by your employer.
- Only companies with 50 or more full time employees are responsible for distributing this form to their full-time employees.
- You may receive multiple Forms 1095-C if you had multiple employers during the year.
- If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible.
- If your employer's plan is self- insured and you were enrolled in your employer's health plan for some of the calendar year or for the whole calendar year, your form 1095-C will have all three Parts completed.
- If your employer plan is fully insured, you will notice only Parts I and II completed, and Part III will be blank.

Form 1095-B Health Coverage

If you were enrolled in your employer's fully-insured health plan for any part of the calendar year, there is one additional form, Form 1095-B Health Coverage, which will be provided by the insurance carrier and will have the information needed to report on your tax return that you, your spouse, and any dependents, had qualifying health insurance coverage (referred to as minimum essential coverage) for some of the year or for the whole year. Individuals that don't have minimum essential coverage and don't otherwise qualify for an exemption may be liable for a tax penalty. If you or a family member obtained minimum essential coverage from another source, such as a government- sponsored program or an individual market plan, the provider of that coverage will furnish you the information about that coverage on Form 1095-B.

Form 1095-A Health Insurance Marketplace Statement

You will receive this form if you purchased health insurance via the Health Insurance Marketplace Exchange. It will provide information for you if you need to complete Form 8962 for the Premium Tax Credit. If you or your family members enrolled in more than one health plan via the Marketplace, you will receive a Form 1095-A for each policy.

The above forms, as applicable to you, will be furnished to you annually no later than January 31st. A copy of each form you receive will also be sent to the IRS.

Notes

Carrier Contact Information

If at any time you have questions regarding Monroe Public School's benefit plan offerings or need assistance, please feel free to contact any of our carriers directly.

Plan	Carrier	Contact Information
Medical	United HealthCare	866-633-2446 myuhc.com
Pharmacy	United HealthCare	866-633-2446 myuhc.com
Dental	Cigna	(800) CIGNA24 (800) 244-6224 www.myCigna.com
Flexible Spending Account & Dependent Care Account	Benefit Strategies/Voya	(888) 401-3539 www.benstrat.com
Health Insurance Consultant	Brown & Brown INSURANCE	Account Manger Adrienne D'Antonio, PHR Emeritus (860) 665-8454 adantonio@bbhartford.com