Mesa Public Schools

2018-2019 Benefits and Enrollment Guide

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Contact Information

Employee Benefits & Risk Management
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www.mpsaz.org/risk

Benefits Guide

Welcome!

Mesa Public Schools is proud to be a vital part of the Mesa community. One reason we are an employer of choice is the rich benefit package we offer eligible employees. As part of MPS, you have numerous benefits available to you. You have a choice of two High-Deductible plans and one traditional plan. In addition, we offer dental, vision, short and long term disability, flexible spending account, automobile insurance, pet care insurance, and many more.

What's New for 2018-2019?

- No increase to Employee Premiums
- We are excited to offer NEW voluntary benefits such as **Accident Insurance**, **Critical Illness** and **Hospital Indemnity Insurance**.
- We are adding VSP KidsCare Plan to meet the eye care and eyewear demands of active and growing children by providing **TWO comprehensive eye exams** and **ONE pair of glasses every year**!
- To better serve our employees, we are transitioning to a new plan year in 2019-2020 school year which will be July 1, 2019-June 30, 2020. Therefore, our plan year for 2018-2019 will be **October 1, 2018 – June 30, 2019**. Your Deductibles and Out-Of-Pocket amounts have been prorated for this 9 month Plan Year.
- Adjustments to pharmacy copays under the OAP plan.
- Adjustments to out of pocket maximums under the HDHP plans.
- Adoption of the Home Delivery Pharmacy for specialty drugs.
- Adoption of the Cigna 90 Now prescription network.

When you enroll, you need to carefully consider the needs of your family. Review the information available to you. Attend any enrollment meetings. When you understand how your benefits work, you will be able to select the best options to provide to you and your loved ones.

Thank you for your dedicated service to Mesa Public Schools.

HOW YOUR RATES ARE CALCULATED THIS PLAN YEAR

With the 2018-2019 Plan Year being 9 months, we want to ensure you understand how your rates will be calculated this plan year. All contributions will be deducted for 18 pay periods for all employees. If you would like the exact payroll dates please see page 18 of this guide.

In 2017-2018 your pay period rates were calculated by:

Taking your monthly rate multiplying by **12 Months** of coverage and dividing by 18 or 24 paychecks depending on your contract.

For 2018-2019, there is no increase to your monthly premium. HOWEVER, you will only pay for **9-Months** of coverage.

For Example, if you are an employee on a less than 12-month contract and have High Deductible Medical coverage:

	2017-2018 Plan Year	2018-2019 Plan Year
Total Months Per Plan	12	9
Premium Per Month	$10.90	$10.90
Total Due (Total Months x Premium Per Month)	$130.80	$98.10
Number of Deductions	18	18
Per Period Amounts (Total Due/Number of Deductions)	$7.27	$5.45

Based on this medical plan the employee will have a **$32.70** Savings in Total Due for the Plan Year in 2018-2019. This is a one-time savings due to the transition of the Plan Year.

If you have any questions, please call the Employee Benefits Department at 480-472-7222.

HOW TO ENROLL

- Go to **MPSAZ.ORG/BENEFITS** and click Benefits Online Enrollment System
- Use your MPS email as your username and your active directory password.
- Click **Enroll Now** button and follow the instructions on how to enroll.
- Instructions are available at mpsaz.org/benefits
- Did you forget your password? Call **Help Desk** at **480-472-0044**.

WHEN CAN I ENROLL?

You may make benefits elections for yourself and your eligible dependents:

- when you are hired as a new, benefits-eligible employee—you must enroll within **31** days
- when you transfer to a benefits-eligible position mid-year you must enroll within **31** days
- when you have a qualified mid-year change event (including a Special Enrollment opportunity), you must enroll within **31** days (60 days for a Medicaid/CHIP event)
- during Open Enrollment when you are benefits-eligible (July 30- August 15).

To Enroll, you must complete online Benefits Enrollment within the designated enrollment opportunity time frame. For more information, contact the Employee Benefits Department.

Have Questions?

Benefits Specialist at Mesa Public Schools can help answer questions you may have.

If your last name starts with:

A- K

Michelle Bernal can help you at **480-472-0367**.

L- Z

Lorraine Wagner can help you at **480-472-0368**.

WHAT IF I MISS THE DEADLINE?

- **As a New Hire/Transfer**—You will only have Basic Life Insurance. You will have to wait until the next Open Enrollment period.
- **During Open Enrollment**—Your current benefits will continue, except for the Flexible Spending Accounts or Dependent Care Flexible Spending Account.

Premiums

Your premiums for your benefits will be deducted on a pre-tax basis via payroll deduction. If you miss any premium deductions, please contact your benefits specialist immediately. This must be done so that your benefits continue without interruption for the remainder of the plan year. The Employee Benefits Department will either adjust your deductions for the remaining pay periods or bill you for missed premiums. You must pay all premiums within fifteen (15) days of the date indicated on the payment notice that will be sent to you. If payment is not received when due, coverage will be canceled for the remainder of the Plan Year. If your benefits are canceled for non-payment of premiums, you will be permitted to re-enroll ONLY during the next Open Enrollment period (or any subsequent Special Enrollment period).

Refunds

- If you pre-paid for medical, dental, vision or life insurance coverage benefits, and are terminated prior to the end of the plan year, a refund of the pre-paid premiums will be returned as taxable wages.
- Refunds (other than for termination) will only be considered when an administrative error by the district has occurred. The member must submit a request within one calendar year of the administrative error, and a refund will only be approved for up to a one-year period.
- Examples of refund requests that will be denied include:
  - Incorrect benefits due to errors in your enrollment or changes not made within 31 days of status change
  - If benefits were used during the period in which a refund is being requested, no refund is permitted.

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MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After the Open Enrollment period is completed, (or, if you are a new hire, after your initial enrollment election period is over), generally you will not be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event or a Mid-year Permitted Election Change Event as outlined below:

Mid-Year Permitted Election Change Event:

Because the District pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year.

The following events **may** allow certain changes in benefits mid-year, if permitted by the Internal Revenue Service (IRS):

- Change in legal marital status (e.g., marriage, divorce/legal separation, death)
- Change in number or status of dependents (e.g., birth, adoption, death)
- Change in employee/spouse/dependent employment status, work schedule, or residence that affects eligibility for benefits
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with special enrollment rights and FMLA leaves

You must notify the plan within 31 days of a mid-year change event by making changes to your coverage via the online enrollment system and providing documentation supporting the change to the Employee Benefits Department. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month following the approved change event (except for newborn and adopted children, who if enrolled, are covered back to the date of birth, adoption, or placement for adoption). The change you request must be consistent with the qualifying event. Please contact the Employee Benefits Department if you have questions.

Special Enrollment Event

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

Marriage, Birth, Adoption Event: If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Medicaid/CHIP Event

You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Employee Benefits Department.

IMPORTANT NOTICE: Duplicate Coverage Prohibited
A husband and wife who are both active Mesa Public Schools employees may not enroll as both an employee and a dependent spouse in the same plans. Duplicate coverage is not permitted under the benefits program. Employees are responsible for ensuring that they and their dependents do not have duplicate District coverage. Duplicate benefits will not be paid.

MEDICAL PLAN CHOICES

For 2018-2019 our plan year will be **October 1, 2018 thru June 30, 2019**, Mesa Public Schools will continue to provide three medical plans through CIGNA. Each plan option are high-quality options, with the same services and network. Make certain you carefully review and compare each plan to determine which best meets the needs for you and your family.

Deductibles & Out-Of-Pocket limits have been prorated to accommodate the 9-month Plan Year. Below is a summary of the medical plans. For a more complete schedule of medical benefits please see your Plan Document. You may request a copy from the Employee Benefits Department or view online at www.mpsaz.org/benefits.

Highlights of the 2018/2019 Medical Plan Options Offered by Mesa Public Schools

	OAP (Cigna OAP Copay Plan)	HDHP 1500 w/HSA (Cigna Choice Plan)		HDHP 2500 w/HSA (Cigna Choice Plan)	
	In-Network only** You Pay:	In-Network You Pay:	Out of Network You Pay:	In-Network You Pay:	Out of Network You Pay:
Annual Deductible					
For employee only	$525	$1,350	$2,250	$1,875	$3,750
For employee + 1	$1,050				
For employee + family	$1,575	$2,700	$4,500	$3,750	$7,500
Out-of-Pocket-Limit					
For one person	$3,175	$3,000	$6,000	$2,625	$5,250
For your family of 2 or more	$6,350	$5,513	$12,000	$5,250	$10,500
Doctor's Office Visits	PCP: $30 copay/visit Specialist: $50 copay/visit	20%*	40%*	10%*	50%*
Urgent Care Facility Visit	$60 copay/visit	20%*	40%*	10%*	50%*
X-rays, lab work Outpatient facility	$0*	20%*	40%*	10%*	50%*
Doctor's Office	Office visit copay applies except for preventive care	20%*	40%*	10%*	50%*
Well Child Care	$0	0%	Not covered	0%	Not covered
Well Women Care	$0	0%	Not covered	0%	Not covered
Adult Preventive Care	$0	0%	Not covered	0%	Not covered
Immunizations	$0	0%	Not covered	0%	Not covered
Hospital Care (Inpatient)	$300 copay per admission, then you pay 20%*	20%*	40%*	10%*	50%*
Emergency room (ER) visit	$250 copay per visit*	20%*	20%*	10%*	10%*
Ambulance service	$0*	20%*	20%*	10%*	10%*
Outpatient Surgery					
Professional Fees	$0*	20%*	40%*	10%*	50%*
Facility Fees	$250 copay*	20%*	40%*	10%*	50%*
Outpatient Physical, Speech and Occupational Therapies up to a combined 50 days per calendar year	$50 copay per visit*	20%*	40%*	10%*	50%*
Mental Health & Substance Abuse Treatment					
Inpatient	$300 copay per admission, then you pay 20%*	20%*	40%*	10%*	50%*
Outpatient	$30 copay/visit	20%*	40%*	10%*	50%*
EAP Visits	EAP Preferred 8 visits - $0	EAP Preferred 8 visits - $0	Not covered	EAP Preferred 8 visits - $0	Not covered

	OAP (Cigna OAP Copay Plan)	HDHP 1500 w/HSA (Cigna Choice Plan)		HDHP 2500 w/HSA (Cigna Choice Plan)	
	In-Network only** You Pay:	In-Network You Pay:	Out of Network You Pay:	In-Network You Pay:	Out of Network You Pay:
Prescription Drugs (Outpatient)					
Annual outpatient prescription drug (Rx) deductible per person	$100 annual deductible per person.	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***
30-day supply (retail)*	Generic - $10 copay Preferred Brand - $40 copay Non-preferred Brand - 40% to a maximum of $120	20%*	40%*	10%*	50%*
90-day supply (mail order)*	Generic - $14 copay Preferred Brand - $70 copay Non-preferred Brand - 40% to a maximum of $200	20%*	Not covered	10%*	Not covered

* *After Deductible.*
** *There is no out-of-network coverage for the OAP Copay Plan, except for emergency services.*
*** *Preventive medications on Cigna's Core list are covered at 100% and not subject to deductible.*

RATES PER PAY PERIOD

OAP Medical (Cigna OAP Copay Plan)	**Employee Contribution** (Per Pay Period)
Employee Only	$32.70
Employee & Spouse	$377.52
Employee & Child(ren)	$319.36
Employee & Family	$533.64
HDHP 1500 (Cigna Choice HDHP 1500 Plan)	
Employee Only	$5.45
Employee & Spouse	$294.89
Employee & Child(ren)	$246.06
Employee & Family	$425.94
HDHP 2500 (Cigna Choice HDHP 2500 Plan)	
Employee Only	$5.45
Employee & Spouse	$262.81
Employee & Child(ren)	$219.39
Employee & Family	$379.31

NEW PHARMACY OPTION BENEFIT

As of October 1, 2018, you will have another option to fill your maintenance medications. Under our three plans, a new maintenance medication program called **Cigna 90 Now** will be included. **Cigna 90 Now** offers you more choices in how, and where, you can fill your prescription. See page 8 for more information.

Did You Know

Cigna Telehealth is an alternative option that lets you connect with a board-certified doctor either via video chat or phone, without leaving your home or work. Cigna provides access to two telehealth services—Amwell or MDLIVE doctors—as part of your medical plan. These services cost less than going to an urgent care clinic and significantly less than an emergency room.

Telehealth Rates

Plan	OAP	HDHP 1500 / HDHP 2500
Amwell	$30/copay	$42 / $49*
MDLive	$30/copay	$42 / $45*

* Effective January 1, 2019

Mycigna app

You're busier than ever. While we can't wave a magic wand, and make all the frustrating, time-consuming aspects of your life go away, we can give you a tool to help make your life easier, and healthier. The **myCigna** Mobile App gives you a simple way to personalize, organize and access your important health information – on the go. It puts you in control of your health, so you can get more out of life. **Get the myCigna Mobile App from the App Store℠ or Google Play™.**

Reminder: Anytime Service at Cigna

Did you know Cigna Customer service is available 24 hours a day/7 days a week? You can speak to a live agent to assist you with any issues you may have.

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90-DAY PRESCRIPTION FILLS

Filling your maintenance medications just got easier with Cigna 90 Now℠

You have a lot going on. Taking your medication every day and remembering to pick up your refill every month isn't always easy. We have a program that can help – it's called Cigna 90 Now.

More choice

Your plan includes a new maintenance medication program called Cigna 90 Now. Maintenance medications are taken regularly, over time, to treat an ongoing health condition. **Cigna 90 Now offers you more choice in how, and where, you can fill your prescription.**

Choose what works best for you

- If you choose to fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in your plan's new network, or Cigna Home Delivery Pharmacy℠.*
- If you choose to fill your prescription in a 30-day supply, you can use any retail pharmacy in your plan's new network.

You choose! 90-day or 30-day supply.

Where you can fill a 90-day prescription

With Cigna 90 Now, your plan offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions.

There are thousands of retail pharmacies in your new network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop! If you prefer the convenience of having your medications delivered to your home, you can also use Cigna Home Delivery Pharmacy to fill your prescriptions.*

For more information about your new pharmacy network, you can go to **Cigna.com/Rx90network**.

Why fill a 90-day supply?

Filling your prescriptions in a 90-day supply may help you stay healthy because having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.** It also means you can make fewer visits to the pharmacy to refill your medication, and depending on your plan, you may be able to save money by filling your prescriptions 90-days at a time.

Here are some of the 90-day retail pharmacies in your network:***

- **CVS** (including Target and Navarro)
- **Walmart**
- **Kroger** (including Harris Teeter Pharmacy, Pick N Save Pharmacy, Fred Meyer Pharmacy, Fry's Food and Drug)
- **Access Health** (including Benzer Pharmacy, Marcs, Big Y Pharmacy, Marsh Drugs, LLC, Snyder Drug Emporium)
- **Good Neighbor Pharmacies** (including Big Y Pharmacy, Super RX Pharmacy, Medical Center Pharmacy, Family Pharmacy, King Kullen Pharmacy)
- **Cardinal Health** (including Freds Pharmacy, Medicine Shoppe Pharmacy, Harris Teeter Pharmacy, Medicap Pharmacy)

*Plans vary, so some plans may not include Cigna Home Delivery Pharmacy. Please check your plan materials for more information on what pharmacies are covered under your plan.
** Internal Cigna analysis performed March 2016, utilizing 2015 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.
*** Participating 90-day network pharmacies as of April 2016. Subject to change

Together, all the way.®

Cigna®

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HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in a one of the High Deductible Health Plans (HDHPs), you may qualify for a Health Savings Account (HSA). This is a savings account that you own to help pay for qualified healthcare expenses not paid by any other health plan.

The eligibility requirements to open and contribute to a Health Savings Account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. **It is an individual's responsibility to ensure that they meet the eligibility requirements to open an HSA account and to have contributions made to that HSA account, as outlined below:**

How do I qualify?

To be eligible to open an HSA and have contributions made to the HSA during the year, you:

- Must be covered by an HSA-qualified health plan (a HDHP) **and must not be covered by other insurance that is not an HSA-qualified plan.**
- Cannot be claimed as a dependent on someone else's tax return,
- Cannot be covered by a general purpose Health Care Flexible Spending Account or by a spouse's health care flexible spending account (FSA),

By law, you are NOT ELIGIBLE for HSA contributions if you:

- are enrolled in Medicare, such as Medicare Part A, B, C or D,
- are covered by another health care plan that is not an HDHP,
- can be claimed as a dependent on someone else's tax return,
- are enrolled in a general Health Care Flexible Spending Account (or covered by a spouse's FSA),
- are covered by a non-HDHP such as TRICARE and TRICARE For Life.

To qualify for the District's monetary contributions to an HSA you must be enrolled in a Mesa Public Schools HDHP.

What happens after I enroll?

An account will be set up and Mesa Public Schools will contribute up to $1,500 ($125 per month of eligibility) for the HDHP2500 and up to $1,000 ($83.33 per month of eligibility) for the HDHP1500 for all eligible employees enrolled in a HDHP. **Funds will be processed on the first payroll of the plan year (October 11, 2018).**

You may also choose to contribute additional funds to your HSA account up to the annual maximum permitted by the IRS which includes both employee and district contributions. Contributions you make will be pre-tax deductions from your paycheck.

Health Savings Contribution Limits		
	2018	**2019**
Health Savings Contribution Limits (Employer + Employee)	Self-Only: $3,450 Family: $6,850	Self-Only: $3,500 Family: $7,000
Health Savings Catch-up contribution (age 55 or older)	$1,000	$1,000

Can I change my Contribution?

You may change your HSA contribution amount at any time using the Mesa Public Schools Online Enrollment System or completing the HSA Change Form located at www.mpsaz.org/benefits.

What happens if I leave the district?

The funds are yours to use for qualified expenses. You will be responsible for any fees that HSA Bank charges to have the account.

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WELLNESS INCENTIVE PROGRAM

October 1, 2018 – June 30, 2019

Up to 40 winners a month will be selected to win a $100 gift card!

1. Complete the Cigna online health assessment and earn 100 points.
2. Complete activities such as free preventive exams or telephonic health coaching for 100 points each.
3. Get entered into a drawing to win a $100 gift card if you have at least 100 points.

The more points you earn, the more chances you have to win.

All employees and spouses on the medical plan who have earned 300 points by June 30, 2019 will be entered into the grand prize drawing for three $1,000 gift cards.

Goal	Description	Points
Complete your personalized health assessment (Start-up goal)	Go to mycigna.com and complete the health assessment with your biometric numbers. This is a confidential questionnaire that asks you about your well-being and provides a personalized assessment of your current health. This is required in order to qualify to earn any other points.	100
Complete a personalized biometric screening	Know your numbers. Work with your healthcare provider to complete screening for blood pressure, cholesterol, blood sugar and body mass index (BMI). Submitted via claims, Quest, or onsite screening.	100
Telephonic Coaching: Talk to a coach and achieve a health goal	Work one-on-one with a health coach on a health goal. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits – Tobacco Cessation	Quitting tobacco is one of the most important things you can do for better health. A health coach can help you take that critical step today. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits - Weight	If you're looking to get to your healthy weight, a health coach can set realistic goals and help you work toward achieving each one. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits - Stress	Lower your stress levels and raise your happiness levels by creating a personal stress management plan with a health coach. Automatically updated by coach.	100
Telephonic Coaching: Achieve a goal to overcome a chronic health problem	Work one-on-one with a health coach on a long-term health problem such as congestive heart failure, depression, diabetes, low back pain, etc. Automatically updated by health coach.	100
Get my preventive well visit (preventive exam)	A preventive exam that's used to reinforce good health, address potential and chronic problems. Verified by claims.	100
Get my annual OB/GYN exam (preventive exam)	A preventive exam that can identify early ovarian and cervical cancers, HPV (human papillomavirus), breast cancer and more. Verified by claims.	100
Get a mammogram (preventive exam)	Breast cancer can be found using mammogram tests. Verified by claims.	100
Get a colon cancer screening (preventive exam)	Colon cancer can be treatable when detected early. Verified by claims.	100
Get a cervical cancer screening (preventive exam)	Pap and HPV tests can detect changes that lead to cervical cancer. Verified by claims.	100
Get a prostate cancer screening (preventive exam)	A prostate screening can detect changes that lead to prostate cancer. Verified by claims.	100

NEW HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance provides a cash benefit in the event of an unexpected hospital stay for a covered illness and /or injury. You and your covered dependents are paid a set benefit amount, depending on your plan and the length of your stay. And you can use the payment in any way you choose – from medical expenses like deductibles, to every day costs, like housekeeping and child care.

Highlights of the 2018-2019 Hospital Indemnity Plan

PLAN INFORMATION	LOW	HIGH
Covered Events	Illness and injury	
BENEFITS		
HOSPITAL CARE		
First Day Hospital Confinement (Up to 1 day per year)	$500	$1,000
Daily Hospital Confinement (Day 2+) (Up to 90 days per year)	$100	$150
Daily ICU Confinement (Day 1+) (Up to 30 days per year)	$200	$300

*For limitations and exclusions visit **www.mpsaz.org/benefits**.

Rates Per Pay Period

Hospital Indemnity	Employee Contribution (Per Pay Period)	
	Low	High
Employee Only	$4.26	$7.54
Employee & Spouse	$8.82	$15.61
Employee & Child(ren)	$8.34	$14.67
Employee & Family	$13.51	$23.81

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NEW CRITICAL ILLNESS INSURANCE

Facing a serious illness can be devastating. Critical Illness insurance can provide a lump-sum benefit upon diagnosis that can be used however you choose (no restrictions apply).

COVERAGE AMOUNTS	LOW	HIGH
Employee Coverage Amount	$10,000	$20,000
Spouse Coverage Amount	50% of your coverage amount	
Child(ren) Coverage Amount	$5,000	
COVERED ILLNESS	**BENEFIT AMOUNTS**	
CANCER CONDITIONS		
Benign Brain Tumor*; Invasive Cancer*	100% of coverage amount	
Non-invasive Cancer	25% of coverage amount	
VASCULAR CONDITIONS		
Heart Attack*; Heart Transplant*; Stroke*	100% of coverage amount	
Aneurysm; Angioplasty/Stent; Coronary Artery Bypass Graft	25% of coverage amount	
OTHER SPECIFIED CONDITIONS		
Coma*; End Stage Renal Failure; Loss of Hearing; Loss of Speech; Loss of Vision; Major Organ Transplant*; Paralysis	100% of coverage amount	
Bone Marrow Transplant	25% of coverage amount	
NEUROLOGICAL CONDITIONS		
Advanced Multiple Sclerosis; Advanced Parkinson's; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	100% of coverage amount	
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**	
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount	
Health Screening Benefit	$50 once per year per covered person	

*For limitations and exclusions visit **www.mpsaz.org/benefits**.

Rates Per Pay Period

Critical Illness Employee Contribution (Per Pay Period)											
Benefit Amount	**Coverage Tier**	**Under 25**	**25-29**	**30-24**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**
$10,000 (Low)	Employee Only	$1.54	$2.06	$2.91	$4.35	$6.85	$10.17	$14.40	$20.07	$27.74	$36.14
	Employee & Spouse	$2.54	$3.34	$4.63	$6.82	$10.66	$15.80	$22.34	$31.11	$42.87	$55.69
	Employee & Child(ren)	$2.61	$3.18	$4.05	$5.49	$7.95	$11.25	$15.45	$21.09	$28.71	$37.06
	Employee & Family	$3.83	$4.67	$5.99	$8.17	$11.98	$17.07	$23.57	$32.30	$44.00	$56.76
$20,000 (High)	Employee Only	$2.55	$3.58	$5.27	$8.12	$13.08	$19.71	$28.16	$39.51	$54.83	$71.63
	Employee & Spouse	$4.06	$5.61	$8.16	$12.49	$20.10	$30.34	$43.41	$60.95	$84.46	$110.10
	Employee & Child(ren)	$3.84	$4.98	$6.71	$9.57	$14.45	$20.99	$29.37	$40.62	$55.82	$72.51
	Employee & Family	$5.64	$7.32	$9.93	$14.25	$21.76	$31.88	$44.84	$62.26	$85.61	$111.11

DENTAL PLANS

The district will continue to offer the choice of two dental plans **Cigna CARE DHMO** and **Cigna PPO** for you and your eligible dependents.

The **Cigna CARE DHMO** plan requires you to see In-Network dentists and offers lower rates and no maximum annual limits. If you are a new subscriber: **You must elect a provider otherwise one will be auto assigned to you using your zip code on file.** If you are **a current subscriber** and would like to change your provider, please call Cigna at 1-800-244-6224.

The **Cigna PPO** allows you to choose in- or out-of-network providers and has deductibles, coinsurance and maximum annual coverage limits.

Highlights of the 2018/2019 Dental Plan Options Offered by Mesa Public Schools

Benefit	CIGNA Dental Care DHMO Plan You Pay:	CIGNA Dental PPO Plan You Pay:	
	In-Network	In-Network CIGNA Advantage	Out-of-Network
Dental Provider Choice	Participants must use an in-network dentist or specialist	Participants may use an in-network or out-of-network dentist	
Dental Plan Annual Maximum	Unlimited	$1,000 per person	
Annual Deductible • For one person • For your family	 $0 $0	 $25 $75	
Diagnostic and Preventive Services • Office visit • Oral Exams • Cleanings • X-rays • Fluoride treatment • Sealants	Scheduled amounts no copays $0 $0 $0 $0 $0 $17 per tooth	$0 with no deductible	20% of allowed amount plus any charges in excess of the allowed amount, after deductible
Basic Treatment • Extractions, simple • Fillings (amalgam) • Fillings (composite for molars) • Root Canal (molar) • Periodontics (scaling, root planing) • Osseous Surgery	Scheduled amounts $53 $17 to $35 per tooth $47 to $115 per tooth $530 $115 per quadrant $350 to $595	20% after deductible	20% of allowed amount plus any charges in excess of the allowed amount, after deductible
Major Treatment • Crown • Full denture (upper or lower) • Partial denture(upper or lower)	Scheduled amounts $370 to $515 $575 $430 -$670	50% after deductible	50% of allowed amount plus any charges in excess of the allowed amount, after deductible
Orthodontia • Adults • Children (to age 19)	Scheduled amounts	Not covered 50% after deductible	50% of allowed amount plus any charges in excess of the allowed amount, after deductible
Lifetime Orthodontia Benefit • Adults • Children (to age 19)	Scheduled Amounts	Not covered $1,000	
Additional Benefits • Specialist Services • General anesthesia (first 30 minutes)	Scheduled Amounts $190	20% after deductible	20% of allowed amount plus any charges in excess of the allowed amount, after deductible

Rates Per Pay Period

CIGNA Dental HMO	Employee Contribution (Per Pay Period)
Employee Only	$0.00
Employee & Spouse	$5.86
Employee & Child(ren)	$7.29
Employee & Family	$8.59
CIGNA Dental PPO	**Employee Contribution (Per Pay Period)**
Employee Only	$13.82
Employee & Spouse	$36.14
Employee & Child(ren)	$37.37
Employee & Family	$46.01

TIP

Dental Cleaning - Preventive care is important. Getting the checkups you need can help you prevent more serious issues from developing or becoming worse and help you save money. Good oral hygiene and oral health can improve your overall wellness. Get your two dental checkups a year—the ADA recommends it and your Cigna dental plan covers it.

VISION BENEFITS

Mesa Public Schools provides vision coverage at no cost for eligible employees through Vision Service Plan (VSP). Employees may purchase vision coverage for their dependents. Vision coverage includes benefits for eye examinations, lenses, frames and contact lenses.

Benefit Description Vision Plan	
Eye Exam payable every: KidsCare: Children have two exams	12 months
Lenses payable every:	12 months
Frames payable every: KidsCare: Frames for Children	24 months 12 months
In-Network Vision Provider	
Exam Copayment:	$15.00
Allowances	
Wholesale frame allowance:	$70.00
Retail frame allowance:	$130.00
Elective contact lenses:	$130.00
Lens Options:	Single vision, lined bifocal and lined trifocal lenses, as well as polycarbonate lenses for children, are included in prescription glasses. Progressive lenses will incur an additional copay (see Benefits website for details).

Vision Plan's Reimbursement for Out-of-Network Provider	
Exam, up to:	$50.00
Single Vision Lenses, up to:	$50.00
Bifocal Lenses, up to:	$75.00
Trifocal Lenses, up to:	$100.00
Lenticular Lenses, up to:	$125.00
Frame, up to:	$70.00
Elective Contact Lenses, up to:	$105.00

Rates Per Pay Period

VSP	Employee Contribution (Per Pay Period)
Employee Only	$0.00
Employee & Spouse	$3.65
Employee & Child(ren)	$3.08
Employee & Family	$5.29

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NEW ACCIDENT INSURANCE

With Accident insurance, you'll receive a lump-sum payment for a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living. For a more complete list of scheduled of benefits visit **www.mpsaz.org/benefits**.

Highlights of the 2018-2019 Accident Plan

PLAN INFORMATION		LOW	HIGH
Coverage Type		Off-job Only	Off-job Only
Benefits			
EMERGENCY, HOSPITAL & TREATMENT CENTER			
Accident Follow-up	Up to 3 visits per accident	$50	$100
Ambulance-Air	Once per accident	$400	$800
Ambulance – Ground	Once per accident	$150	$300
Daily Hospital Confinement	Up to 365 days per lifetime	$100	$200
Daily ICU Confinement	Up to 30 days per accident	$200	$400
Diagnostic Exam	Once per accident	$100	$200
Emergency Room	Once per accident	$100	$200
Hospital Admission	Once per accident	$1,000	$2,000
Initial Physician Office Visit	Once per accident	$25	$50
Rehabilitation Facility	Up to 15 days per lifetime	$50	$100
Urgent Care	Once per accident	$25	$50
X-ray	Once per accident	$50	$50
SPECIFIED INJURY & SURGERY			
Abdominal/Thoracic Surgery	Once per accident	$1,500	$2,000
Burn	Once per accident	Up to $5,000	Up to $10,000
Burn – Skin Graft	Once per accident for third degree burn(s)	25% of burn benefit	25% of burn benefit
Concussion	Up to 3 per year	$100	$200
Dislocation	Once per joint per Lifetime	Up to $4,000	Up to $6,000
Eye Injury	Once per accident	Up to $150	Up to $300
Fracture	Once per bone per accident	Up to $5,000	Up to $8,000
Hernia Repair	Once per accident	$100	$200
Joint Replacement	Once per accident	$2,000	$3,000
Knee Cartilage	Once per accident	Up to $600	Up to $800
Laceration	Once per accident	Up to $300	Up to $600
Raptured Disc	Once per accident	$500	$750
Tendon/Ligament/Rotator Cuff	Once per accident	Up to $400	Up to $800

*For limitations and exclusions visit **www.mpsaz.org/benefits**.

Rates Per Pay Period

COVERAGE TIER	LOW	HIGH
Employee Only	$2.10	$3.73
Employee & Spouse	$3.35	$5.94
Employee & Child(ren)	$3.60	$6.36
Employee & Family	$5.63	$9.96

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to use pre-tax dollars to pay for qualified healthcare or dependent day care expenses. The money you elect to put into a Health FSA through regular, equal payroll deductions is available to be used throughout the year. Even better, the deductions are made on a pretax basis, meaning you don't pay federal, Social Security, and in some cases state taxes, on the amount you set aside in the FSA.

Three FSA accounts are available. As a reminder, our Plan Year for 2018-2019 will be **October 1, 2018 – June 30, 2019**. During this shortened plan year, FSA maximum contribution limits are prorated:

- General Purpose Healthcare FSA – HCFSA – (For individuals not enrolled in a HDHP) used to pay eligible medical, dental and vision expenses - $1,980 annual maximum
- Limited use Healthcare FSA - Ltd-HCFSA - (For individuals enrolled in a HDHP) – used to pay eligible dental and vision expenses only - $1,980 annual maximum
- Dependent care FSA – DCFSA – used to reimburse eligible day care, child care and elder care expenses - $5,000 annual maximum.

If you want the FSA, YOU MUST ENROLL IN THESE ACCOUNTS EVERY YEAR. You determine the amount you want to contribute to an FSA at the beginning of each plan year and you may access these funds throughout the year. You may not change your FSA election during the plan year unless you have a qualifying mid-year change event or a special enrollment event. Funds in your FSA that are not used for expenses within the plan year are forfeited.

LIFE INSURANCE BENEFITS

Basic Life Insurance

As an eligible district employee, you receive basic life insurance at no cost to you. The basic life benefit amount is $50,000 for all full-time eligible employees. You automatically receive the basic life coverage. It is your responsibility to keep your beneficiary designation up to date. If you have eligible dependents, they receive basic dependent life insurance coverage.

Supplemental Life Insurance

You may choose supplemental life insurance coverage in $10,000 increments up to a maximum of $500,000. Newly eligible employees may choose the lesser of up to four times your annual salary in guaranteed coverage or up to $500,000 (without completing an Evidence of Insurability form). If you select coverage greater than four times your annual salary for yourself, you must complete and submit an Evidence of Insurability form to be approved by Sun Life.

Supplemental Spouse Life Insurance

Newly eligible employees may choose to purchase coverage for your spouse of up to $50,000 guaranteed coverage without completing an Evidence of Insurability form. If you apply for coverage greater than $50,000 and up to $500,000 for your spouse, an Evidence of Insurability form must be completed and approved by Sun Life. Spouses already enrolled in life insurance are grandfathered in for their current limits. Spouses may not enroll for an amount greater than the employee basic plus employee supplemental life.

Supplemental Dependent Life Insurance

You may choose to purchase coverage of $5,000, $10,000 or $15,000 for your eligible children up to age 26. The premium is the same regardless of the number of children.

SHORT-TERM DISABILITY PLAN

You are eligible to enroll in Short-Term Disability (STD) benefits if you work 30 or more hours per week. STD benefits help replace lost income if you cannot work because you are totally disabled due to a non-work accident or illness, including pregnancy. Employees purchase STD coverage based on their salary. STD benefits begin the first day of an accident and on day eight for sickness and pregnancy. The maximum length of STD coverage is 26 weeks. Benefits are paid biweekly and calculated using your weekly salary (less any overtime, bonuses or other forms of extra pay). There is a twelve-month pre-existing condition limitation that applies to new enrollments and increases in coverage.

EMPLOYEE ASSISTANCE PROGRAM

All employees are eligible to receive confidential counseling benefits through the district's Employee Assistance Program (EAP). You and your eligible family members are automatically covered and receive up to 8 counseling sessions per event per person per year at no cost to you. The EAP provides confidential, personal assessments, and referral services through **EAP Preferred**.

You can **confidentially discuss** your situation and find resources and information for personal difficulties such as:

- Family or marital problems
- Parenting concerns
- Grief over the death of a loved one or other losses
- Drug and alcohol dependence
- Emotional difficulties such as depression, anxiety and guilt
- Eating disorders such as anorexia
- Conflicts at work
- Job stress
- Crisis Situations

RETIREMENT PLAN OPTIONS

Retirement may be just around the corner or may be far on the horizon — but it is never too late or too early to start saving. Mesa encourages you to take care of your future by planning well today. To assist employees in saving for retirement, Mesa is pleased to offer a 403(b) Savings Plan, 403(b) Roth, 457(b) Deferred Compensation Plan and 457(b) Roth Plan. Please visit the Benefits website for contact information for these plans.

VOLUNTARY BENEFITS INFORMATION

Mesa Public Schools offers a comprehensive choice of voluntary benefits that allow employees to purchase additional coverages through convenient payroll deduction, electronic payments or direct billing. We have negotiated attractive group rates for the following insured products and services:

- Group auto insurance through Horace Mann – (480) 839-1404
- Pet insurance through United Pet Care – (602) 266-5303

2018-2019 DEDUCTION SCHEDULE

Premiums are deducted from the following pay periods biweekly. An 'X' specifies a deduction:

Pay Date	18 PAYCHECKS (Everyone)
10/11/2018	X
10/25/2018	X
11/08/18	X
11/21/18	X
12/6/2018	X
12/20/2018	X
1/03/2019	X
1/17/2019	X
1/31/2019	X

Pay Date	18 PAYCHECKS (Everyone)
2/14/19	X
2/28/19	X
3/13/19	X
3/28/19	X
4/11/19	X
4/25/19	X
5/09/19	X
5/23/19	X
6/06/19	X

FOR HELP OR INFORMATION

When you need information, please refer to the contacts listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
INFORMATION NEEDED	**WHOM TO CONTACT**
Medical Plans Claims Administrator • Claim Forms (Medical) • Medical Plan Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • Summary of Benefits and Coverage (SBC)	**CIGNA HealthCare (CIGNA)** Open Access Plus (OAP or OA Plus) Customer Service: 1-800-244-6224 (1-800-CIGNA24) HDHP Customer Service: 1-800-244-6224 (1-800-CIGNA24) Website: **www.mycigna.com** Claim Submittal Address: CIGNA MPS Group Number: 3333634 P. O. Box 182223 Chattanooga, TN 37422-7223 Appeals Submittal Address: CIGNA Healthcare MPS Group Number: 3333634 National Appeals Unit P. O. Box 188011 Chattanooga, TN 37422
Medical Plans Provider Network (called **Open Access Plus** or **OAP** or **OA Plus**) • OA Plus Medical Network Provider Directory for the **CIGNA Open Access Plus Network** • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	**CIGNA HealthCare (CIGNA)** Open Access Plus (OAP or OA Plus) Customer Service: 1-800-244-6224 (1-800-CIGNA24) HDHP Customer Service: 1-800-244-6224 Website: **www.cigna.com** and select the Open Access Plus Network **CAUTION:** Use of a **non-network** hospital, facility or Health Care Provider could result in you having to pay a substantial balance on the provider's billing (see definition of "balance billing" in the Definition chapter of this document). Your lowest out of pocket costs will occur when you use In-Network providers.
Utilization Management (UM) Program • Pre-authorization (precertification) of Admissions and Medical Services • Case Management • Appeals of UM decisions	**CIGNA HealthCare (CIGNA)** Open Access Plus (OAP or OA Plus) Customer Service: 1-800-244-6224 HDHP Customer Service: 1-800-244-6224
Prescription Drug Plan • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Direct Member Reimbursement (for Non-network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering	**CIGNA HealthCare (CIGNA)** Customer Service: 1-800-244-6224 Specialty Drug Customer Service: 1-800-285-4812 CIGNA Home Delivery Pharmacy Customer Service: 1-800-285-4812 P. O. Box 1019 Horsham, PA 19044 Website: **www.mycigna.com** Quit Today Smoking Cessation Program: Call 1-800-224-6224 to enroll

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QUICK REFERENCE CHART

INFORMATION NEEDED	WHOM TO CONTACT
Employee Assistance Program (EAP) • Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.	**EAP Preferred** Telephone: 602-264-4600 or 1-800-327-3517 Website: **www.eappreferred.com** Enter username: **MESAUSD** Enter password: **eappreferred**
Behavioral Health Program ***for all medical plan options*** • Mental Health and Substance Abuse Services and Providers • Precertification of Certain Behavioral Health Services • Behavioral Health Claims and Appeals	**CIGNA HealthCare (CIGNA)** Customer Service: 1-800-244-6224 (1-800-CIGNA24) Website: **www.mycigna.com** or **www.cignabehavioralhealth.com**
Healthy Pregnancy Healthy Babies Program • The CIGNA Healthy Pregnancies, Healthy Babies® program can help, providing education and support throughout your entire pregnancy – and after, if you complete the program, you could be eligible to receive an incentive of up to $150. • Healthy Pregnancy Healthy Babies is a collection of CIGNA benefits and an educational mailing available to you as part of your CIGNA HealthCare administered medical plan of benefits. The mailing includes a list of web resources, list of pregnancy related topics in the 24 hour Health Information Line audio library, a magazine, and brochures from the March of Dimes.	**Healthy Pregnancy Healthy Babies Program from CIGNA** Call 1-800-244-6224 Website: **www.mycigna.com**
Your Health First Program • Free health support services. CIGNA's Your Health First health experts trained as nurses, pharmacists, behavioral clinicians and health educators. They're available Monday through Saturday to speak with you one-on-one. They can help you find the best and most cost-effective health professionals and services in our area. You can call to ask questions about ways to improve your health and get additional information about medication and treatment options that your doctor may have mentioned. • Improve your lifestyle with effective stress, tobacco or weight management. • Better manage conditions such as depressions, asthma, diabetes and more • Make the best decisions about treatment for common conditions like low back pain or heart disease. • Find ways to reduce health care costs by savings money on medications, treatments or other health related expenses.	**CIGNA Your Health First** The phone number is on the back of your ID card or call 1-800-244-6224.

QUICK REFERENCE CHART

INFORMATION NEEDED	WHOM TO CONTACT
Cancer Treatment Support Program • CIGNA's Cancer Care Support Program offers people with cancer assistance from Cigna nurse coaches as they make critical decisions regarding their medical care, treatment and recovery. • The CIGNA Cancer Support Program provides access to a specially trained cancer nurse to assist you one-on-one. Your nurse can help you understand your diagnosis, medications, treatment options identified by your doctor and help answer any questions you may have. In addition, CIGNA can help you coordinate your care, understand your insurance coverage, and find additional resources like local support groups and facilities.	**Cancer Treatment Support Program from CIGNA** Call 1-800-244-6224 Website: **www.mycigna.com**
Dental PPO Plan Claims Administrator • Dental PPO Network Provider Directory • Dental PPO Plan Claims and Appeals	**CIGNA Dental PPO** Customer Service: 1-800-244-6224 (1-800-CIGNA24) MPS Group Number: **3333634** Website: **www.mycigna.com**
Dental HMO Plan (Dental Care HMO) • The insured Dental HMO plan benefits are NOT fully described in this document. Contact the Employee Benefits Office for further information.	**CIGNA Dental Care HMO** Customer Service: 1-800-244-6224 (1-800-CIGNA24) MPS Group Number: **3333634** Website: **www.mycigna.com** Locate Provider Website: **www.cigna.com** and select the Cigna Dental Care HMO
Vision PPO Plan Claims Administrator • Vision PPO Network and Provider Directory • Vision PPO Plan Claims and Appeals	**Vision Service Plan (VSP)** Customer Service: 1-800-877-7195 MPS Group Number: **12-140015** Website: **www.vsp.com**
Health Savings Account (HSA) Bank	Contact CIGNA Customer Service: 1-800-244-6224 Website: **www.mycigna.com**
COBRA Administrator • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	**Mesa Public Schools** ATTN: COBRA Specialist 63 East Main Street Suite 101 Mesa, AZ 85201 Phone: 480-472-7222 Secure Fax: 480-472-0370
Employee Benefits Office **Plan Administrator** **HIPAA Privacy and Security Officer** • Medicare Part D Notice of Creditable Coverage • HIPAA Notice of Privacy Practice	**Employee Benefits and Risk Management** 63 East Main Street Suite 101 Mesa, AZ 85201 Phone: 480-472-7222 Secure Fax: 480-472-0370 Email: **benefits@mpsaz.org**

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QUICK REFERENCE CHART

INFORMATION NEEDED	WHOM TO CONTACT
Life Insurance and Accidental Death and Dismemberment Insurance • The life insurance and accidental death and dismemberment insurance benefits are not fully described in this document. Contact the Employee Benefits Office for further information. • Submit death claims to the Employee Benefits Office at: 63 East Main Street, Suite 101; Mesa, AZ 85201. Phone: 480-472-7222 Fax: 480-472-0370.	**Sunlife** 1-800-247-6875 Website: **www.sunlife.com/us**
Flex Benefits Claims Administrator • Health FSA both General Purpose and Limited Purpose for HDHP participants • Dependent Care FSA	**CIGNA Healthcare** Customer Service: 1-800-244-6224 (1-800-CIGNA24) Website: **www.mycigna.com**
Short Term Disability	**Dearborn National** 1-877-348-0487
Benefits Online Enrollment	**BenefitFocus** 1-877-336-8082
Retirement	**Arizona State Retirement System (ASRS)** 3300 N Central Ave Phoenix, AZ 85012 Member Services: 602-240-2000 Enrollment Code: **1YV00006**
Plan Administrator/Plan Sponsor	**Governing Board of the Mesa Unified School District #4** 63 East Main Street, Suite 101 Mesa, AZ 85201 Phone: 480-472-7222 Fax: 480-472-0370 Email: **benefits@mpsaz.org** Web Site: **www.mspaz.org/benefits**

IMPORTANT NOTICES

This section contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document.

NOTICE OF MPS PRIVACY PRACTICE

HIPAA Privacy pertains to the following group health plan benefits sponsored by Mesa Public Schools:

- Self-funded medical, prescription, dental and vision plans
- Medical reimbursement account provisions of the flexible spending account (both the general purpose and limited purpose health flex plans)
- COBRA Administration

This Plan's HIPPA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. To obtain a free copy of this Plan's HIPAA Notice of Privacy Practice for the above noted group health plan benefits, write or call the Employee Benefits Department at 63 E. Main Street #101, Mesa AZ 85201-7422, (480) 472-7222 or access your benefits website at www.mpsaz.org/benefits/publications.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the District. For more information, refer to your medical Plan Document or call the Employee Benefits Department at (480) 472-7222.

NEWBORN'S AND MOTHER'S 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 of a newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact the Utilization Management program to precertify the extended stay. If you have questions about this Notice, contact the Employee Benefits Department at (480) 472-7222.

MEDICARE NOTICE OF CREDITABLE COVERAGE

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the Medical plan options offered by the District are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available from Employee Benefits or on the benefits website at **www.mpsaz.org/benefits/publications.**

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFITS AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly Summary of Benefits and Coverage SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice,SBC, summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages the SBC should be the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

A Uniform Glossary that defines many of the terms used in the SBC is available at **https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbcuniform-glossary-of-coverage-and-medical-terms-final.pdf**.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to **www.mpsaz.org/benefits** or contact the Employee Benefits Department at (480) 472-7222.

Caution: If You Decline Medical Plan Coverage Offered Through Mesa Public Schools

The medical plan options offered by the District are considered to be minimum essential coverage (MEC) and meets the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages

If you are in a benefits-eligible position and choose not to be covered by one of Mesa Public Schools medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace **(www.healthcare.gov)**, typically at the Marketplace annual enrollment in the fall each year.

TAX INFORMATION

In December 2017 Congress passed a new law (the Tax Cuts and Jobs Act) that reduced the Individual Mandate penalty to zero starting in 2019. This means that starting in 2019 there will no longer be a federal Individual Mandate penalty for failure to maintain medical plan coverage.

Note that if you are a resident of certain states, such as Massachusetts, New Jersey, or Vermont, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state Individual Mandate penalty.

If you choose to not be covered by a medical plan sponsored by the District at this enrollment time, your next opportunity to enroll for your employer's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of the District's plan year.

Important Reminder To Provide The Plan With The Taxpayer Identification Number (TIN) Or Social Security Number (SSN) Of Each Enrollee In A Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://**www.socialsecurity.gov/online/ss-5.pdf**. Applying for a social security number is FREE.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the Employee Benefits Department at (480) 472-7222.

UNEMPLOYMENT INSURANCE

The district pays the cost of unemployment insurance on your behalf. Should you become unemployed for any reason, you may apply for unemployment insurance at your local office of the state Department of Economic Security. This department will determine if you are eligible to receive unemployment compensation. For more information, contact your local Department of Economic Security Office.

WORKERS' COMPENSATION

If you have a job-related illness or injury that requires medical care (beyond first aid) and/or requires you to take time off from work, you may file a claim for Workers' Compensation benefits. You may report your injury to your Supervisor and complete a Supervisors Report Of Injury (SROI). Arizona Workers' Compensation Law provides compensation benefits for employees who have a job-related illness or injury. Those benefits may be less than the total wages an employee would otherwise earn. For more information, please call the District Workers' Compensation office at (480) 472-0366.

REASONABLE ACCOMMODATIONS FOR INDIVIDUALS WITH DISABILITIES

The district is committed to providing equal employment opportunities for individuals with disabilities and does not discriminate on the basis of a disability in the admission, access, treatment or employment in its programs or activities. The district has established a return-to-work program to assist injured and/or ill employees in continuing gainful, productive and rewarding employment. For additional information about reasonable accommodations, please contact the Risk Management Department at (480) 472-0369.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is an order or a judgment from a court or administrative body directing the Plan to cover a child of a participant under the group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions about the procedure for determining if the order is valid, please contact the Employee Benefits Department.

UNIFORMED SERVICE EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Service Employment and Reemployment Services Act (USERRA) is temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services for more than 31 days. The employee will be offered the opportunity to elect temporary coverage under COBRA or USERRA. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

HEALTH CARE REFORM

The Affordable Care Act (commonly called Health Care Reform) has been changing the country's health-care system from the moment it was signed into law back in March 2010. Mesa Public Schools' benefit programs work hard to implement the required Health Care Reform provisions such as coverage for dependent children to the age of 26, removing pre-existing condition limitations in the medical plans, removing lifetime and overall annual limits in the medical plans, and adding comprehensive preventive/wellness services for children and adults to all medical plan options.

The wellness/preventive services payable by our medical plans are designed to comply with Health Care Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). These websites list the types of no cost preventive services including immunizations and the information on the websites are updated periodically throughout the year:

- **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**
- **http://www.cdc.gov/vaccines/schedules/hcp/index.html**
- **https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/**
- **http://www.hrsa.gov/womensguidelines/**

If you have questions on whether a particular service will be payable as a preventive service, please contact CIGNA at 1-800-CIGNA24.

PATIENT PROTECTION RIGHTS AFFORDABLE CARE ACT

If you are enrolled in any of the district's medical plans, you do not need prior authorization from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology (OB/GYN), contact

CIGNA at 1-800-CIGNA24.

Also, the district's medical plans do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider, however, payment by the Plan may be less for the use of a non-network provider. To locate an in-network provider, visit **www.cigna.com**.

INFORMATION ON EMPLOYEE FRAUD AND ABUSE

Fraud, abuse and unethical conduct in connection with the benefits provided through the District Employee and Retiree Health and Welfare Benefits Program is a serious issue. Fraud and abuse can take many forms, including:

- Adding a dependent to your coverage who you know is not eligible for coverage,
- Submitting false or altered affidavits or documentation as part of adding or removing a dependent,
- Letting someone else who is not covered under your enrollment use your insurance card to get health benefits or services,
- Lying to get coverage or access to health benefits (such as prescription drugs or treatments) that are not medically necessary,
- Giving or selling your prescriptions to another person, or
- Submitting reimbursement requests for health benefits or services that were not provided.

The Employee Benefits Department must investigate allegations of fraud and abuse. Each plan and benefit option has programs to look for and eliminate fraud and abuse. If fraud or abuse is determined to have taken place, there can be serious consequences, including:

- Lock-down of your prescription benefits to only one doctor or pharmacy,
- Termination of coverage, or
- Restitution for any claims/benefits that were inappropriately paid.

Serious criminal or civil consequences may result.

NOTICE ABOUT DISCLOSURE AND USE OF YOUR SOCIAL SECURITY NUMBER

A federal mandatory reporting law (Section 111 of Public Law 110-173) requires group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. Two key elements required to be reported are social security numbers (SSNs) of covered individuals (or HICNs) and the plan sponsor's employer identification number (EIN). For Medicare to properly coordinate payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable. As a member (or spouse or family member of a member) covered by a group health plan arrangement, your SSN and/or HICN will likely be requested to meet the requirements of this law. For more information about the mandatory reporting requirements under this law, visit the CMS website at **www.cms.hhs.gov/MandatoryInsRep**.

Because of the tax benefits of employer-sponsored health benefits coverage, we require your SSN to ensure that your income tax and other employment-related taxes are properly calculated and withheld from your paycheck.

GENERAL NOTICE OF CONTINUATION OF COVERAGE (COBRA) RIGHTS

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when certain events occur and, as a result of the event, coverage of that qualified beneficiary ends (together, the event and the loss of coverage are called a qualifying event). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events may include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation or a child ceasing to be an eligible dependent child under the terms of the plan, if a loss of coverage results. The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs. That notice must be sent to the Benefits Department via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See **https://www.healthcare.gov**/. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for Marketplace coverage or for the tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

If you have questions about COBRA contact the Employee Benefits Department at (480) 472-7222.

LEAVE/CONTINUATION OF COVERAGE WHILE ON LEAVE OF ABSENCE

If you take a Leave of Absence without pay or a leave of absence pursuant to the Family Medical Leave Act (FMLA), special rules govern the continuation of your health benefits. You have several options for your health benefits coverage while you are on leave, including whether to keep your coverage in place or drop it and how to pay for health benefits coverage while you are on leave. You should review the options and make an informed decision. Contact your Employee Benefits Specialist for details, and visit the Employee Benefits Department website.

FAMILY AND MEDICAL LEAVE ACT (FMLA) REMINDER

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles. Eligible employees are entitled to twelve (12) workweeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six (26) workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

All covered employers are required to display and keep displayed a poster prepared by the Department of Labor summarizing the major provisions of The Family and Medical Leave Act (FMLA) and telling employees about their rights and responsibilities and how to file a complaint. We display the FMLA poster at our worksites. More information on FMLA is available at: **http://www.dol.gov/whd/fmla/** or contact the Employee Benefits Department.

Certain Employee Responsibilities Related to FMLA: Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When a 30-day notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish, to the District's Employee Benefits Department, information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events. Note that for certain changes like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give the District's Employee Benefits Department a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact the District's Employee Benefits Department.

Employer Notice About The Health Insurance Marketplace

The District distributes a notice to new employees when they are first hired. The notice is at least two pages long. To help you recognize the notice, here is a snapshot of a portion of the first page of the Notice:

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **January 31, 2018**. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: **www.myalhipp.com** Phone: 1-855-692-5447	Website: **http://dch.georgia.gov/medicaid** - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: **http://health.hss.state.ak.us/dpa/programs/medicaid/** Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.hip.in.gov** Phone: 1-877-438-4479 All other Medicaid Website: **http://www.indianamedicaid.com** Phone 1-800-403-0964
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: **http://www.colorado.gov/hcpf** Medicaid Customer Contact Center: 1-800-221-3943	Website: **www.dhs.state.ia.us/hipp/** Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: **http://flmedicaidtplrecovery.com/** Phone: 1-877-357-3268	Website: **http://www.kdheks.gov/hcf/** Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: **http://chfs.ky.gov/dms/default.htm** Phone: 1-800-635-2570	Website: **http://www.dhhs.nh.gov/oii/documents/hippapp.pdf** Phone: 603-271-5218

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331** Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711	Website: **http://www.nyhealth.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: **http://www.mass.gov/MassHealth** Phone: 1-800-462-1120	Website: **http://www.ncdhhs.gov/dma** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://mn.gov/dhs/ma/** Phone: 1-800-657-3739	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://www.oregonhealthykids.gov** **http://www.hijossaludablesoregon.gov** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx** Phone: 1-855-632-7633	Website: **http://www.dhs.pa.us/hipp** Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: **http://dwss.nv.gov/** Medicaid Phone: 1-800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **http://www.scdhhs.gov** Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx** 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**
Website: Medicaid: **http://health.utah.gov/medicaid** CHIP: **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

To see if any other states have added a premium assistance program since **January 31, 2018**, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 12/31/2019)


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PUBLIC SCHOOLS