BENEFITS OPEN ENROLLMENT-**AIDES**

PUBLIC SCHOOLS OF PETOSKEY

PLAN YEAR:	01/01/2019 – 12/31/2019
ENROLLMENT PERIOD:	NOVEMBER 2018 (**FORMS DUE DATE: NOVEMBER 30, 2018**)
EFFECTIVE DATE:	JANUARY 1, 2019
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Benefits Open Enrollment Month is the time to choose Insurance or Cash-in-Lieu of Insurance and enroll in Flexible Spending Accounts or Health Savings Accounts (*optional*) for the next school year. It is also the time to change or enroll in MESSA optional plan selections.

Listed below are the 2019 estimated Medical Co-Premium contributions for **Aides,** for those with CONTINUING coverage**. Please call the payroll office for co-premiums if you are switching from the cash option to insurance, or switching plans.** There is no charge for dental and vision coverage. The monthly Co-premium contributions will be deducted from 18 pays according to the schedule to the right →

PAK A: MESSA ABC Plan 1, $1350/2700 Deductible, NO Co-insurance, MESSA Rx		
Co-Premium Contributions for Medical Coverage, per PAY:		
Single	**2-Person**	**Family**
$52.79	**$168.67**	**$169.37**
PAK A- There are no HSA Annual Employer Contributions		

PAK C: MESSA ABC Plan 1, $1350/2700 Deductible, 10% Co-insurance, MAIL Rx		
Co-Premium Contributions for Medical Coverage, per PAY:		
Single	**2-Person**	**Family**
$25.78	**$107.92**	**$93.76**
PAK C- There are no HSA Annual Employer Contributions		

Deduction Schedule
1/25/2019
2/8/2019
2/22/2019
3/8/2019
3/22/2019
4/19/2019
5/3/2019
5/17/2019
5/31/2019
6/14/2019
9/20/2019
10/4/2019
10/18/2019
11/1/2019
11/15/2019
11/29/2019
12/13/2019
12/27/2019

If you decline medical coverage, the cash-in-lieu rate is based on the 2019 Single-subscriber State insurance cap amount:

Cash-In-Lieu Incentive	
20 pays (1/11/19-6/14/19) & (9/20/19-12/27/19)	**$200.56 (Per Pay)**

EVERY EMPLOYEE MUST COMPLETE NEW ENROLLMENT FORMS EACH PLAN YEAR:

ALL FORMS ARE ATTACHED BUT ALSO LOCATED ON THE PAYROLL WEBPAGE.

➢ STEP 1. BENEFIT PLAN ELECTION FORM

- Please check appropriate box, Option A (Insurance) or B (Cash-in-lieu). Check the type of plan, PAK A or PAK C, that you choose for your insurance package.

➢ STEP 2. ONLINE BENEFITS WEBSITE

- Locate **MESSA USER GUIDE** for your open enrollment. Follow the directions to **verify/update** any information on the online MESSA web-portal. **ALL employees must go online and complete your enrollment** whether Pak A or Pak C (medical/dental/vision) or Pak B (dental/vision). If you have any questions during the process, please contact the payroll office #2350. PRINT or EMAIL the confirmation for your records.

➢ STEP 3. INSURANCE WAIVER (CASH-IN-LIEU)

- **If taking insurance go to step 4.** If you are waiving insurance and requesting a cash payment in lieu of, you must complete and "certify" the waiver below. ALL information MUST be provided to ensure your cash payment.

➢ STEP 4. SALARY REDUCTION AGREEMENT

- Please choose one of the three options on the front page of the Salary Reduction Agreement. If you have chosen to waive the insurance for the cash payment, you must still complete this form. Anyone may choose to participate in the Dependent Care Reimbursement listed on the back of the form. For more information about Flexible Spending Accounts/HSA Savings account please see the IRS rules at : HTTP://WWW.IRS.GOV/PUB/IRS-PDF/P969.PDF *Note: If you choose the Healthcare Flex Spending account, you will be ineligible for the funding to your HSA account.

➢ STEP 5. PRINT AND TURN IN FORMS

Once you have completed your forms, please print them "ON BOTH SIDES" as indicated. Please sign the forms and turn them in to the payroll office. Thank you~

Important ! → **Be sure you have signed all forms**

REMINDER: The only changes allowed after open enrollment period is closed are those with a change of family status or qualifying event. Change of family status must be done within 30-days of event (i.e. marriage, divorce, births, etc.)

Please view the Petoskey Schools Payroll page for information on the following Notices:
Insurance Marketplace Coverage
District's HIPAA Privacy Practice notice
Notice Regarding Automatic Enrollment Procedures
Summary of Benefits and Coverage (SBC)

PUBLIC SCHOOLS OF PETOSKEY

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

WHO YOU CAN COVER UNDER THE MEDICAL PLAN:

- Yourself;
- Your Spouse;
- Your eligible children through the end of the year in which the individual turns age 26.

HIPAA SPECIAL ENROLLMENT PERIODS

Loss of Other Coverage

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing to the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing to the other coverage).

New Dependent

If you gain a new dependent as the result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

CHILDREN'S HEALTH INSURANCE PROGRAM AND MEDICAID ELIGIBILITY CHANGES

If you or your dependents are eligible for medical coverage in this Plan but are not enrolled, you have 60 days to enroll in the Plan in the following two circumstances:

- If you or your eligible dependents' Medicaid coverage or coverage under the state Children's Health Insurance Program (CHIP) is terminated due to loss of eligibility; or
- If you or your dependents become eligible for a premium assistance program in the state in which you reside.

MICHELLE'S LAW NOTICE

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

For the protections of Michelle's Law to apply, the child must:
• Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
• Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan. If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides group health benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema (swelling caused by the removal of lymph nodes). Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

NEWBORNS AND MOTHERS HEALTH PROTECTION NOTICE

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth 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 health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Health Plan will not require a provider to obtain authorization from the Health Plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

NOTICE OF ELIGIBILITY FOR HEALTH PLAN RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service.

- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect continuation coverage under USERRA.

PATIENT PROTECTION NOTICES

If the Plan provides for or requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining

prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room.

Your plan covers both in-network and out-of-network emergency services. Your out-of-pocket costs are the same, but you may pay more for out-of-network care in other ways. For example, an out-of-network provider is allowed to bill you for some things that in-network providers can't bill you for.

W-2 REPORTING

The health care reform law requires some employers to report the cost of employer sponsored group health coverage. You may see this reported in Box 12 of your W-2 form. This is an employer reporting requirement only and it won't have an impact on your taxable income or require you to report it on your personal income taxes.

HEALTH INSURANCE EXCHANGE

Beginning in 2014, state/federal-run programs called "health insurance exchanges" will allow individuals and qualified small employers to comparison-shop for health insurance online. Plans in the exchange will have standard levels of benefits – for example, a "gold" plan will have certain features and a "silver" plan will have certain features. Subsidies will be available to low-income people and small businesses that buy insurance through an exchange.

HIPAA NOTICE OF PRIVACY PRACTICES

Your employer is committed to maintaining the privacy of protected health information for participants in the Plan. This is a reminder that in compliance with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) a Notice of Privacy Practices is available to employees. This notice of Privacy Practices explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy or for further information regarding the issues covered by this Notice of Privacy Practices, please contact the Plan Administrator.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to help you maintain your health coverage when you need to change jobs. If you lose coverage under the Plan, the Plan will provide you with a certificate that shows how long you had coverage under the Plan. This is your "creditable coverage." Using this certificate of creditable coverage, you will be able to reduce or eliminate any pre-existing condition exclusion imposed by a new employer plan or group insurance policy. You will automatically receive a certificate:

- When you become a qualified beneficiary entitled to elect COBRA coverage.
- When you lose medical coverage, even though you are not entitled to elect COBRA coverage.
- When your COBRA continuation coverage ends.

You may also request a certificate at any time or within 24 months after your medical coverage ends.

NOTICE OF ELECTIVE ABORTION RIDER

Effective March 13, 2014, the Abortion Insurance Option Opt-Out Act requires health plans to cover elective abortion services only through an optional rider purchased by the group at an added cost. As required under the new law, this notice is to inform you that elective abortion coverage continues to be a part of your benefit plan.

Please note the abortion coverage under this rider may be used by any covered dependent without notice to the employee participating in the plan.

Elective abortions are defined by the Act.

Examples of elective abortions include those performed for the following reasons:

- Protect the health of the mother
- Birth defects of the fetus
- Pregnancy because of rape or incest
- Performed for any reason other than for medical reasons

Note: Elective abortions do not include the use of a drug or device intended as a contraceptive.

Non-elective abortions include those performed to:

- Increase the probability of a live birth
- Preserve the life or health of the child after live birth
- Remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman
- Avert the death of the pregnant woman (when termination of the pregnancy is necessary in the physician's reasonable medical judgment)
- Treat a woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy