Swanton Local Schools

2020/2021 Benefits Guide

PICKING THE BEST BENEFITS…
FOR YOU AND YOUR FAMILY

SWANTON LOCAL SCHOOL DISTRICT strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you are getting the most out of our benefits—that's why we've put together this Benefits Guide.

This booklet is intended to be utilized during Open Enrollment and when initially hired. Open Enrollment is a short period of time before your groups renewal date that allows you to alter or change your benefit elections. This guide will outline all of the different benefit options available, so that you can identify which offerings are best for you and your family.

If you have questions about any of the benefits mentioned in this guide, please contact Laura Kuhlman, Payroll Coordinator, in the Treasurer's Office.

This guide is intended for informational purposes only.

Eligibility

Who is Eligible for Benefits?

If you are a full-time employee unless otherwise stated in a negotiated agreement (working 30 or more hours per week) you and your family members are eligible to enroll.

Open Enrollment

Open Enrollment is the month of May and is the time for you to make changes to any benefit offerings. The benefits you elect during open enrollment will be effective September 1st

How do I Make Changes? What is a Qualifying Event?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period.

Qualified Life Events for Status Change:

Marriage: You are required to report a marriage to your employer, within 31days. A copy of the marriage license and insurance company applications are required to change your name, beneficiary, address, or to add or delete dependents from the benefit plans. If your new spouse is eligible for group health coverage through their employer, they may not be eligible to enroll under your policy.

Birth/Adoption: You are required to add a new child, either by adoption or by natural birth, within 31days from the date of birth or acquisition. A copy of the Birth Certificate or Court document is required.

Court Orders: If you are enrolling a dependent child(ren), whose coverage might be governed by a divorce decree, or other support order, please look at your documents carefully. Depending upon how your divorce or court order was written, the dependent may NOT be eligible for this plan. *If your court order specifies that the other parent is responsible for health insurance coverage* (or payment of health care claims if there is no insurance), *then this plan might not cover your child(ren)*. A copy of the court documents or Medical Support Notice is required to enroll a dependent child(ren).

Different last name for spouse or children: Insurance companies or your employer may require proof such as marriage license, birth certificate, court document, or recent tax form, to show that dependents with different last names are your legal dependents. Enrollment or payment of claims may be pended until proof is received. Please be prepared to submit this documentation if requested by the carrier or your employer. Your dependent may not be enrolled if documentation is not received when requested.

Divorce or Legal Separation: If you become legally separated or divorced, it is required that you submit a copy of the appropriate finalized court papers within 31 days of the event in order to make any changes to your plan elections. You may be unable to change your plan elections without this documentation.

Spousal Carve-out Policy

Spouse are required to comply with the following eligibility provisions of the Swanton Local School District Health Benefits Plan. The Plan requires that if the employee's spouse is eligible to participate in their employer's group medical/prescription drug plan, and that plan costs less than $150 monthly (for Bus Drivers, Teachers, and Secretaries) to the employee, he/she must enroll in that plan. For non-union, these requirements stand if the plan costs less than $100 monthly. The spouse can remain on the Swanton Local School District Health Benefits Plan as secondary coverage. A spousal health benefits compliance form is required. If your spouse loses their coverage and is ineligible under another employer-sponsored plan, he/she can enroll in or plan within 30-days from the date coverage is terminated.

Adult Children Policy

The federal government has passed legislation that allows children up to age 26 to remain covered under their parents insurance. Adult dependent children may be married or unmarried and do not need to live with or be financially dependent upon the covered employee. However, if these adult dependents are eligible to participate in their employer-sponsored health plan, and that plan costs less than $150 monthly (for Bus Drivers, Teachers, and Secretaries) to the employee, the Swanton Local School District Health Benefits Plan requires that the adult child's employer-sponsored health plan be the primary coverage; while our health plan will be secondary. For non-union, these requirements stand if the plan costs less than $100 monthly. An adult child health benefits compliance form is required.

Medical Insurance

Below is an overview of the current plan design with Paramount Healthcare. Participating providers and hospitals can be found at www.paramounthealthcare.com.

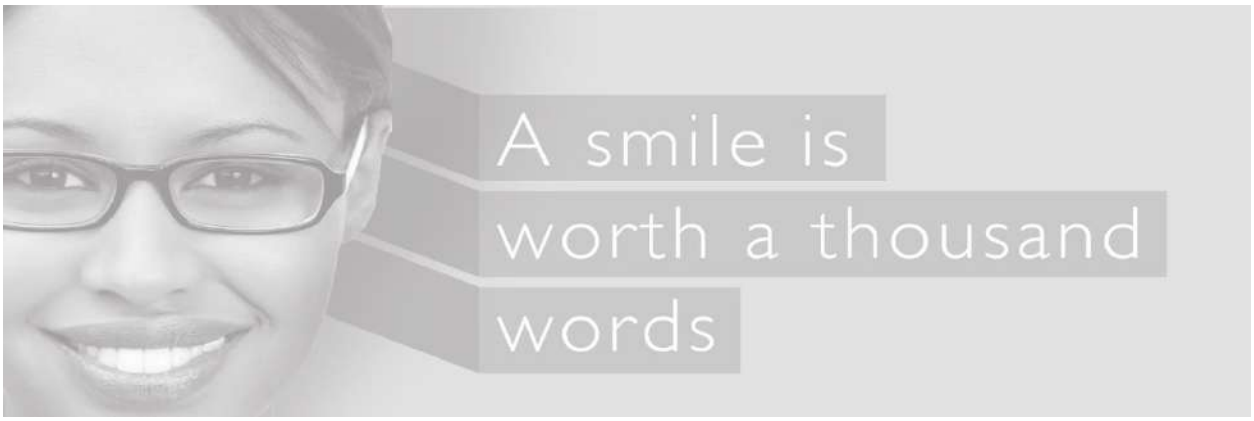
Please note: Your dependent children are eligible to be on this plan until the end of the month in which they turn the age of 26.

Plan Provisions (Displayed In Network Benefits)	**Paramount**
Deductible (single/family)	$100 / $200 Out of Network: $500 / $1,000
Coinsurance %	20% after Ded.
Out-of-Pocket Max, incl deductible (single/family)	$2,100 / $4,200 Out of Network: $4,500 / $9,000
Office Visit Copay (PCP/Specialist)	$20 / $40
Inpatient/Outpatient Co-Insurance	20% after Ded.
Preventive Services	Paid at 100%
Emergency Room / Urgent Care Copay	$125 / $50

Prescription Benefits:
Prescription drugs are administered separately through RxBenefits with CVS Caremark's drug plan. You will receive a separate ID card with this detail.

Retail	10% - Generic 20% - Preferred Brand 30% - Non-Preferred Brand & Multi-Source Brand
Mail Order	10% - Generic 20% - Preferred Brand 30% - Non-Preferred Brand & Multi-Source Brand
Out-of-Pocket Max	$2,000 per person $4,000 per family

Monthly Premium:
Employees pay a portion of the medical/Rx premium. Please refer to your negotiated agreement or non union fringe beneft packet for more information.



Dental Insurance – Self Funded Plans

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

The following chart outlines the dental benefits we offer.

- Employee pays 10% of the cost of this coverage
- The coinsurance percentage remains the same whether you use a Dentemax dentist or not

Dental Services	
Preventive Services	0% - Exams, cleanings, x-rays
Deductible	None
Basic Services	20% - Fillings, simple extractions
Major Services	40% - Oral surgery, root canal, crowns
Annual Maximum	$2,000 per person
Orthodontia	40% Lifetime Max Benefit is $1,500

Special Provisions
* Cross application or cross applied means that the out-of-network deductible, coinsurance limit and out-of-pocket limit will satisfy the in-network deductible, coinsurance and out-of-pocket limit. However, the in-network deductible, coinsurance and out-of-pocket limit will not satisfy the out-of-network deductible, coinsurance and out-of-pocket limit.
** Primary Care Provider (PCP) designation is required to receive In-Network Benefits.
*** A member must call Utilization Review at 1-800-991-2549 (also shown on your id card) to notify of non-emergency out-of-network hospital admission. Failure to make the call will result in a $200 penalty. When an out-of-network provider is being used for covered services, the member is responsible for call Paramount for pre-notification.

If the coinsurance percentage remains the same, why would I use a Dentemax dentist? The answer is simple would you rather pay 20% of a $200 ($40) for filling or 20% of $120 ($24) for the same procedure. You could save $130 or more for a crown. Dentemax contracts with dentists to accept a lower allowed amount. The patient has a lower out-of-pocket cost for quality dental services. Prices can vary by dentists.

DENTEMAX

800.752.1547 | DenteMax.com

Why Use DenteMax?

DenteMax has been delivering a quality national dental PPO network since 1985.

Access *to one of the BEST dental networks in the country*

- Over **282,000** credentialed dentist access points nationwide
- Adding hundreds of new dentists each month

Quality *dentists*

- Every DenteMax dentist undergoes rigorous credentialing before they can join the network
- DenteMax takes pride in offering high-quality dentists; you will be treated by the best of the best

Savings *from **20% to 40%** when you visit a network dentist*

- Reduce out-of-pocket costs
- Stretch annual maximum benefits
- Receive network discounts on services even after your annual maximum is reached or on services that are not covered benefits; in applicable states

	Crown		Root Canal	
	DenteMax	Non-Network	DenteMax	Non-Network
Amount Charged	$560	$800	$700	$1,200
Member Co-Pay	25%	25%	25%	25%
Plan Pays	$420	$600	$525	$900
Member Pays	$140	$200	$175	$300
In-Network Member Savings	$60	-	$125	-

* *The example above shows what your out-of-pocket costs would be for two common dental procedures. It assumes a 25% co-pay.*

Using DenteMax is as easy as...

1. Call your plan administrator to verify your coverage
2. Find a DenteMax provider online at DenteMax.com or call our customer service line at (800) 752-1547
3. Make an appointment & be sure to mention your dental plan uses the DenteMax network

Important Information for 2019 FSA PLAN PARTICIPANTS

As your plan year comes to a close, we wanted to provide you with important reminders about your plan.

1. **KEEP YOUR EXISTING CDA CARD.** If you elect to participate in the upcoming 2020 plan year, your new election will be loaded automatically to your existing card at the beginning of the new plan year.

2. **Check your remaining 2019 balance.** Login to your portal at https://cdatpa.lh1ondemand.com/ or call the toll-free number on the back of your Card to see what's left in your account for the plan year. Any unused funds remaining in the plan after the final processing of expenses submitted within the filing period are forfeited and become assets of the plan (except for Health FSA: only funds in excess of the $500 Carryover Provision are forfeited).

3. **Be sure to use up your 2019 FSA funds before your plan's deadline.** Remember to submit any outstanding claims or receipts for expenses incurred during the plan year no later than November 30, 2020.

   Health FSA: Any unused funds remaining in the plan, in excess of the $500 carryover provision limit, after the final processing of expenses submitted within the filing period are forfeited and become asset of the plan. Your 2019 benefit is only available on the CDA card through August 31, 2019. To be reimbursed for any 2019 expenses after August 31, 2019, you must submit a claim to CDA for reimbursement. **Do not use your CDA card to pay for any 2019 service dates or expenses after August 31, 2019.**

   Dependent Care FSA: Any unused funds remaining in the plan after the final processing of expenses submitted within the filing period are forfeited by the employee and become assets of the plan. Your plan offers a 2½ month grace period provision which allows you to incur expenses through November 1[illegible] 2020 and pay for those expenses to spend down any remaining 2019 balance. Any dependent care expenses incurred on November 15, 2020 or earlier and submitted to CDA by November 31, 2020 will be considerd a grace period claim and will be automatically paid from a remaining 2019 balance prior to 2020 funds being used.

4. **Respond to outstanding documentation requests.** Any open documentation requests for current plan year transactions remain open and still need to be replied to. Failure to respond to a request will result in card suspension until which time the transaction is properly substantiated. Failure to properly substantiate any transactions or repay overpayments under the plan will be the responsibility of the cardholder, including but not limited to all IRS compliance, income tax and penalty implications.

5. **There should be no reason to lose any of your account balance due to not having eligible expenses.** If you discover you may have had a little too much deducted throughout the plan year and you do not have enough eligible medical, dental or vision expenses, we suggest shopping at online pharmacy stores, such as FSAStore at www.cdatpa.com/shopfsa. You may search through their inventory for commonly used items and the website will show you if the item is an eligible over the counter item without the need for a physician's prescription.

Have questions? Contact CDA, LLC at 1-877-810-2600

Swanton Local School District
Flexible Spending Account (FSA) 2020
Plan Year: September 1, 2020 to August 31, 2021

Your benefit election may only be used to pay for service dates on or after September 1, 2020. Do not determine your 2020 election with the intent to pay for any remaining balances from prior years, as the expense is not eligible.
Regardless of when you receive a bill, you cannot be reimbursed or pay for an expense from your FSA with a purchase/order date or service date prior to the beginning of the plan year date above.

Health Care FSA Benefit

- Consider what medical expenses you anticipate having next year for you and any eligible dependents (copays, deductibles, eye exams, eyeglasses, dental visits, orthodontia, etc.) A Health Expense Worksheet and Eligible Expenses List is enclosed to help you with this process. Once you have reviewed your estimate, determine your annual election. Your election will be divided by the number of pay periods during the plan year and deducted before taxes from each paycheck.
- **The Health Care FSA has a minimum annual election of $100 and maximum annual election of $2,650.**
- **The Health Care FSA contains the Carryover provision (for remaining balances of up to $500).**
- **Spending Deadline: All claims must be incurred on or before August 31, 2021.**
- **Claim Filing Deadline: All claims for the 2020 plan year must be submitted to CDA, LLC no later than November 30, 2021.**
- The full amount of the annual election is available to spend for qualifying expenses on the first day of the plan year.
- **Participants need to save all documentation/receipts (Health FSAs are IRS-regulated benefits and the IRS requires submission of receipts before CDA may reimburse or substantiate an expense). Credit card receipts are not acceptable receipts. Cash register receipts are only acceptable when submitting over-the-counter expenses for reimbursement; the receipt must provide a clear explanation of the item(s) purchased. Samples of acceptable documentation include:**
  - **Insurance Explanation of Benefits**
  - **Itemized invoices from medical, vision and dental providers (only after insurance is finalized). Cannot be balance forward statements and must contain services rendered/items purchased, original service date(s), patient name, provider name and contact information, etc.**
  - **Pharmacy receipt (the detailed receipt stapled to the prescription bag, not the cash register/credit card receipt).**

Dependent Care FSA Benefit

- Consider what expenses you anticipate having for the care of a qualified dependent or person while you work—the cost of care associated with the person's well-being and protection. Once you have reviewed your estimate, determine your annual election. Your election will be divided by the number of pay periods during the plan year and deducted before taxes from each paycheck.
- **The Dependent Care FSA has a minimum annual election of $100 and maximum annual election of $5,000.**
- **The Dependent Care FSA contains a 2 1/2 month Grace Period Spending Extension provision.**
- **Spending Deadline: All claims must be incurred on or before November 15, 2021.**
- **Claim Filing Deadline: All claims for the 2020 plan year must be submitted to CDA, LLC no later than November 30, 2021.**
- Dependent Care FSA funds are ONLY available to pay expenses as deductions are taken from pay.
- Qualified dependents or persons are:
  - A qualifying child under age 13 whom you can claim as a dependent. Child who turn 13 during the year are considered a qualifying person for the part of the year they are under age 13.
  - A disabled spouse or other person who was not physically or mentally able to care for himself or herself who meets the remaining IRS guidelines regarding residency, claimant status, etc.
- Qualified dependent care providers can include: certain family members, private daycare providers, licensed childcare daycare centers, nursery schools, preschools, before/after-school care, day camps, adult day care.
- **Participants will be required to submit itemized/detailed receipts (Dependent Care FSAs are IRS-regulated benefits and CDA requires submission of receipts to reimburse expenses). A provider must be willing to provide detailed statements/receipts for care to permit for reimbursement under the plan, which must also include a Federal Tax ID Number or Social Security Number of the caregiver to be filed with your annual tax return.**

THE JEFFERSON HEALTH PLAN EAP – QUICK FACTS SHEET

Program Name:	**The Jefferson Health Plan EAP**
Toll-Free Number:	877-233-0976
EAP Website:	www.achievesolutions.net/JHP

Eligibility:
Plan participants enrolled under the member organization's Jefferson Health Plan coverage, including employees, spouses & dependents are eligible for the benefits offered through the EAP Program. In addition, any other household members of a JHP covered employee may use the EAP. Employees of JHP member organizations who are not covered by the Jefferson Health Plan are also eligible.

EAP Counseling:
5 visits per problem or issue: services are delivered by licensed, experienced behavioral health clinicians and may occur face-to-face, via secure video or telephonically per the member's preference

Legal & Financial Benefit:
A free consultation per problem or issue can be accessed through the toll-free number. Additional services beyond the initial consultation are available at a discounted rate. Self-serve tools for building standard legal documents and modeling financial commitments such as retirement planning and mortgage terms, in additions to relevant articles and other resources are available on the EAP website.

Work-Life Balance Benefit:
Assistance is available for locating and connecting with referral services for such Work-Life Balance challenges as childcare, eldercare and concierge assistance with daily living needs; e.g., planning special occasions and travel, locating reliable skilled tradesmen to address home and household needs, help with unexpected personal / family events, etc.. Related information and resource locator tools are available on the EAP website.

Management Consultations:
Consultation on workplace, employee and team issues, including planning for a referral of an employee to the EAP, can be accessed through the toll-free number. This assistance is not limited in occurrence.

Management Referrals:
Assistance with planning for and implementing formal referrals related to job performance and/or job jeopardy is available through the toll-free number.

Crisis Incident Debriefing:
Onsite services are available per-hour (minimum 2hrs); contract hours available, after hours exhausted, benefit is offered on a Fee-for-Service basis. Call the toll-free number to make arrangements.

Orientation & Training:
Orientation and Training are available per-hour; contract hours available, after hours exhausted, benefit is offered on a Fee-for-Service basis. Call the toll-free number to make arrangements.

When you choose the right benefits at the right time of your life, you're truly making your benefits count. All of these programs pay in addition to the core Swanton Schools Benefit Plan.

Short Term Disability

- Employee pays the full cost of this coverage
- Pays in the event you become disabled from a non-work-related injury or sickness
- Cost is based on your salary

Accident Insurance

- Employee pays the full cost of this coverage
- Pays in the event you have a sports related injury, broken bone, burn, concussion, laceration, and much more!

Cancer Insurance

- Employee pays the full cost of this coverage
- Helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer that most medical plans don’t cover

Critical Illness Insurance

- Employee pays the full cost of this coverage
- Pays a lump sum benefit if you are affected by a critical illness. May help with costs such as lost income, travel and lodging, medical expense, and rehabilitation

Life Insurance

- Employee pays the full cost of this coverage
- Pays a lump sum benefit to your beneficiary in the event of death to assist with funeral expenses, medical but in the event you become disabled from a non-work-related injury or sickness

Contacts

Who do I contact if I have questions regarding my benefits?

For general questions regarding your benefits, you may contact Laura Kuhlman at (419) 826-7575 or laura.kuhlman@swantonschools.org.

Your Insurance Carriers Contact Information

If your question is in regards to how something is covered under a specific benefit or regarding a claim, you should contact your insurance carrier directly for the fastest answer. Below are carrier specific phone numbers:

Medical: Paramount Healthcare (419) 887-2525 www.paramounthealthcare.com

Prescriptions: RxBenefits through Caremark
RxBenefits (800) 334-8134 https://www.rxbenefits.com/
CVS Caremark (800) 772-7475 CVS Caremark https://www.caremark.com/wps/portal?ALT_AUTH=Y

Dental: Self Funded Plans (800) 722-7374
DenteMax network https://www.dentemax.com/

What do I do if I am not sure a medical bill was properly paid?

Collect all billing statements and Explanations of Benefits (EOBs) that relate to your claim. Match up the bills with the EOBs, so you can compare how the insurance company processed the claim with how you've been billed. (If you don't have a matching EOB, call the number on your ID card to make sure the insurance company received it.) If the amounts don't match, call your doctor's office and ask them why you're being billed a different amount from what the EOB says you owe.

Who do I contact with additional questions?

If you have tried to resolve an issue with the insurance company on any of the following items and are unable to get the answers you need, Stapleton Insurance can help! Your representative's name is **Amanda Bialecki** and she can be reached at **(419) 720-0323** or Amanda@Stapletoninsurance.com

- Plan information or explanation
- Help with claims
- Information on eligibility
- Help with doctor, hospital or other provider issues
- Help with prescriptions

What changes can I make during open enrollment?

You can enroll or terminate individual and/or dependent coverage in all the plans offered to you in this guide.

For New Hires: When and how do I get my ID cards?

You will receive your ID cards at your home 7-10 days after your application has been processed. To request replacement or additional cards, you can log onto the carrier specific websites and make a request.

What forms do I need to complete at initial enrollment, or with a qualifying event?

You will need to complete a provider specific enrollment form for each coverage you wish to purchase and/or participate in. Forms to be completed:

- Medical: Paramount Enrollment/Change Form
- Dental & Rx: Self Funded Plans Enrollment Form
- Voluntary Products: Colonial Enrollment Form
- Spousal Compliance Form: (if adding spouse to coverage)
- Adult Dependent Compliance Form (if adding adult dependent to coverage)
- CDA Enrollment Form

Summary of Benefits and Coverages (SBC) and Summary Plan Description

SBC's will be provided to each employee at initial enrollment, and during open enrollment. SBC's are always available when requested. Please contact the Treasurer's Office if you did not receive your copy.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Swanton Local School District reserves the right to alter, revise, modify or otherwise make changes to this policy at any time, with or without notice.

Women's Health and Cancer Rights Act

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:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as determined during a consultation with the attending physician and patient.

These benefits will be provided subject to annual deductibles and coinsurance provisions as appropriate and consistent with those established for other benefits under the health plan.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Plans cannot set the level of benefits or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a less favorable manner for the mother or newborn than any earlier part.

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, a mother may be required to receive prior approval to use certain providers or facilities, or to reduce out-of-pocket costs. If your plan contains a precertification requirement, you or your provider must still get prior approval for the stay to avoid any additional out-of-pocket expenses. However, your stay will automatically be approved for 48 or 96 hours, as specified by law.

COBRA or State Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) generally provides that certain qualified beneficiaries who lose coverage under an employer-sponsored health plan may elect to continue under the plan in certain situations. This is for groups with over 20 employees. State Continuation is applicable for smaller employee.

Medicare & Medicare Part D

If you are 65 or older and are actively at work, working full time you may remain on our group health insurance plan as Primary. In some instances, it may be beneficial to review options to enroll with Medicare Part A & B, Medicare Supplements and Medicare Part D.

If you or your dependent is eligible for Medicare, you (or they) may defer enrollment into one of Medicare Part D programs until later, since you are already covered under our employer-sponsored prescription drug plan. People who are eligible to enroll in Medicare Part D benefits at age 65, but decide not to enroll until later, will have the opportunity to enroll in Part D benefits between October 15th and December 7th each year during open enrollment. We have determined that the prescription drug coverage offered by our plan on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. This will allow you to keep your current coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

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 are 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 are not eligible for Medicaid or CHIP, you will not 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 healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State offering premium assistance, contact your State Medicaid or CHIP office to determine if premium assistance is available to you. More information is available at Medicaid.gov under the CHIP tab. 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 877-KIDS-NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that will 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 are not 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 regarding enrolling in your employer plan, contact the Department of Labor at askebsadol.gov or call 866-444-EBSA (3272).

Premium Expense Plan (Section 125)

The Premium Expense Plan is allowed under the IRS tax code. It reduces your amount of taxable income by allowing you to pay for your insurance premiums on a pre-tax basis. All employees participating in the insurance plans are eligible, and an Authorization Form is required. IMPORTANT NOTICE: In accordance with federal regulations, the benefits you choose will remain in effect through the next plan year. However, you may be allowed to make changes in certain benefits if you have a Qualified Event. Qualified Events are limited to the following: - Marriage – Legal Separation – Annulment or Divorce – Death of a spouse or dependent – Birth or adoption of a child or addition of a dependent – Loss of eligibility of a dependent child – Termination or commencement of a spouse's employment.

HIPPA Privacy Policy

Want to receive a copy of the Group Health Plan's Notice of Privacy Practices? Contact your employer's privacy or benefits department.

Genetic Information Nondiscrimination Act (GINA)

GINA, along with the Health Insurance Portability and Accountability Act (HIPPA), prohibits discrimination in group health plan coverage based on genetic information. GINA also prohibits a health plan from requesting or requiring you or your dependents to take a genetic test, requesting or requiring genetic information (including family medical history) or imposing a pre-existing condition exclusion provision based solely on genetic information.

FMLA – Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job

Employees are eligible if they have worked for a covered employer at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.