FOCUS ON BENEFITS

September 2021

QUESTIONS

Shari Berget at **608-862-3225 ext. 2410** or **shari.berget@Albany.k12.wi.us**

In this issue

What's new?

Elections you make during open enrollment will become effective September 1, 2021.

This brochure includes the benefits and enrollment material offered at The School District of Albany for 2021/2022 plan year. We encourage you to take the time to read through and explore your benefits options. At The School District of Albany, we value our employees and are committed to providing a comprehensive and competitive benefits package.

Certain benefits you elect require an employee contribution. In some cases, those contributions will be deducted from your check on a pre-tax basis; in other cases the deduction will be made after-tax to avoid certain tax consequences to you and the company. For taxability of benefit elections, please contact Shari Berget at 608-862-3225 ext. 2410 or **shari.berget@albany.k12.wi.us**.

Required notices are located at the end of this packet and include:

- HIPAA Portability Notice
- Initial COBRA Notice
- Notice of Healthcare Exchange
- Medicare Part D Coverage Notice
- CHIP Notice
- WHCRA Notice

HEALTH PLAN SUMMARY

Effective September 1, 2021, we will continue to offer a health plan through Dean for all benefit-eligible employees.

About the Health Plan: Preventive care is covered at 100% and no deductible applies. For other services, this plan requires a deductible before eligible services are paid at 100%.

The School District of Albany will contribute to your HSA account to help with your deductible or other qualified medical expenses. **The HSA will be funded at $1,875 single and $3,750 family.**

Features	HMO In-Network	POS / PPO In-Network	POS / PPO Out-of-Network
Deductible *per calendar year*	$3,000/single $6,000/family	$3,000/single $6,000/family	$6,000/single $12,000/family
Out of Pocket Max *per calendar year*	$3,000/single $6,000/family	$3,000/single $6,000/family	$12,000/single $24,000/family
Physician Services *Office visits, Urgent Care Clinic, Retail Health Clinics, Chiropractic Manipulation*	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible
Preventive Services *Well child, Immunizations, Certain Prenatal Services, Screening*	You pay $0	You pay $0	You pay 20% after deductible
Mental/Behavioral/ Substance Use	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible
Chiropractic/Physical/ Occupational/Speech Therapies	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible
Ambulance	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible
Hospital	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible
Prescription Drugs *Retail (31 day supply) GenRx preferred drug list including preferred generic, preferred brand* *Specialty Drugs* *90 dayRx / Mail Order GenRx preferred drug list including preferred generic and preferred brand. Specialty drugs are in specialty networks.*	You pay 0% after deductible	You pay 0% after deductible	You pay 20% after deductible Not covered Not covered

Please review your benefit plan summary document for more detailed coverage information.

Looking for a convenient clinic or hospital location? Dean's provider finder lets you easily search for providers and locations within your network. Search on our website for a location convenient for you.

BALANCE BILLING

The amount that the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Always use an in-network provider for the highest coverage of services.

SUMMARY OF BENEFITS COVERAGE

Refer to your summary of benefit coverage (SBC) for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

QUESTIONS?

Call customer service at **608-294-6463**, **800-718-3326** or call the phone number on the back of your ID card or visit **www.deancare.com**.

HEALTH SAVINGS ACCOUNT ADVANTAGES

Is a health savings account right for me?

Like any health care option, an HSA has advantages and disadvantages. As you weigh your options, think about your budget and what health care you are likely to need in the next year.

If you are generally healthy and want to save for future health care expenses, an HSA may be an attractive choice.

Or if you are near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement.

Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage.

If you are covered on the High Deductible Health Plan (HDHP), but you are also covered on another group health plan (such as your spouse's group plan) that is not an HDHP, you are ineligible to make contributions to an HSA.

Also an HSA is not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.

Please notify HR if you become enrolled in Medicare or other disqualifying coverage so that HSA contributions can be terminated to avoid adverse tax consequences for you. If you are eligible for, but not enrolled in, Medicare please contact HR before deciding to continue any HSA contributions.

How much can you put in the health savings accounts?

Maximum contributions are $3,600 for single coverage and $7,200 for family coverage for 2021 (employer and employee contributions combined).

Your Health Savings Account will be offered through **Associated Bank**. To enroll, you must fill out and return applicable forms.

TOP REASONS TO HAVE AN HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep.

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests, and prescription medications.

Reduced Insurance Premiums — The cost of coverage under a qualified HDHP is typically lower than the other plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax-deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, however, taxes will be imposed.)

Safety Net — An HSA has no "use it or lose it" restrictions, so balances can be built up to use for major medical events.

Coverage for the "Extras" — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over a certain amount may be invested.

Empowerment — Take control of your health care decisions, including which providers you want to use, to ensure your health care dollars are spent wisely.

How do I use the HSA to pay for medical care?

It is rather simple. Here are the steps:

1. You and/or the company puts money into the HSA.
2. You or a dependent receives medical services.
3. A bill for medical services is submitted as a claim to Dean Health Plan.
4. You receive an Explanation of Benefits for the medical service, which will reflect the amount due to the provider.
5. At this time you can choose to:
    - Use your HSA funds to pay the provider directly for the amount due
    - Pay the provider with personal funds and request reimbursement from your HSA funds
    - Use your personal funds and save your HSA dollars for future medical expenses
6. This process repeats until your deductible and out-of-pocket maximums are met for your Dean Health Plan, after which benefits are paid for by Dean Health Plan for the remaining plan year.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to www.deancare.com to search for providers and clinics that offer the medical services you need at the best cost.

Can I withdraw money from an HSA for nonmedical expenses?

Yes, but if you withdraw funds for nonmedical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.

BE A SMART HEALTHCARE CONSUMER!

You have different care options to choose. Gaining a better understanding of your options now can help you save both time and money when you need to seek care. Options for treatment include:

Convenience Care, Online Care: Located inside of retail stores or online, visit these for common aliments like strep throat, pink eye, bladder infection, etc. **Cost: $**

Doctor's Office: Staffed by doctor, PA and nurses, visit this for care of illnesses, injuries, preventive care, etc.
Cost: $$

Urgent Care Clinic: Staffed by doctor, PA and nurses, visit this for care of minor illnesses or injuries that require **immediate** attention.
Cost: $$$

Emergency Room: Located inside of a hospital, visit this for serious illnesses, injuries or life-threatening issues, such as, chest pains, shortness of breath, burns, head injuries, etc.
Cost: $$$$

HEALTH PLAN PREMIUMS

The School District of Albany will continue to pay a portion of your premiums. Premiums are shown per pay period for full-time employees effective September 1, 2021:

HMO - 24 Pay Periods	Per pay Period
Employee	$36.27
Family	$83.42

Part-time employees will pay a higher portion of premiums than shown.

If you are interested in a POS plan or eligible for a PPO plan, please contact Shari Berget in the District Office for more information on costs.

Cash In Lieu of Health Insurance Premiums: If you are eligible for coverage and choose to waive coverage due to alternate employer sponsored coverage the district will pay Cash in Lieu of **Health Insurance Premiums as and Alternate Benefit,** subject to normal income taxes. Please contact Shari Berget for the benefit amount.

LIVE TOBACCO FREE

We strongly believe that you and your family should strive to be as healthy as possible. One of the best things you can do for your health is to quit smoking and stop using tobacco.

For more information, call the number on the back of your card.

DENTAL PLAN SUMMARY

About the Dental Plan: This is a comprehensive plan for all dental services and covers preventive care at 100% in-network, with no deductible. You may use any dentist for your dental services; however, using an in-network provider will reduce your out-of-pocket costs.

Features	Delta Dental PPO	All Other Dentists
Annual Maximum	$1,000	$1,000
Annual Deductible *Does not apply to preventive and diagnostics*	N/A	N/A
Diagnostic & Preventive	You pay $0	You pay $0
Basic Restorative Care *Amalgam & Resin Fillings*	You pay 20%	You pay 20%
Oral Surgery *Simple Extractions*	You pay 20%	You pay 20%
Endodontic Therapy *Root Canal*	You pay 50%	You pay 50%
Periodontics *Gum disease*	You pay 20%	You pay 20%
Major Restoratives *Resins, Crowns*	You pay 50%	You pay 50%
Prosthetics and Implants	You pay 50%	You pay 50%

Dental Plan Premiums: We pay 100% of your premiums for full-time employees. These rates are shown monthly and effective September 1, 2021.

Status	Monthly Rates
Employee only	$45.43
Family	$117.40

Please review your plan summary document for more detailed coverage information.

DELTA DENTAL®

We offer the Delta Dental PPO dental plan. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

INFORMATION ON THE GO!

Access your dental account information from your smartphone or mobile device with Dental Delta app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist
- Brush with toothbrush timer

AMPLIFON HEARING HEALTHCARE

As a Delta Dental member, you receive discounts and savings on hearing diagnostic testing, along with the guaranteed lowest pricing on hearing aids. Call 888-901-0132 or visit www.amplifonusa.com/deltadentalWI for information.

QUESTIONS?

Call customer service at **800-236-3712** or call the phone number on the back of your ID card or visit **www.deltadentalwi.org**.

VOLUNTARY VISION SUMMARY

Our Materials Only Vision plan is offered through Delta Dental

About the Vision Plan: This is a materials only plan because a routine vision exam is included in your medical plan through Dean. Delta partners with Eye Med to offer vision benefits. You may use any provider for your vision services; however, you get a greater benefit by using a provider within the Eye Med network.

Features	Participating Provider	Non-Participating Provider
Lenses / Frames (1x/12 mos.) (Clear, Glass or Plastic) *Single, Bifocal, Trifocal* *Lenticular* *Progressive*	$250 allowance, then 20% off balance	$125 allowance
Contacts (1x/12mos) *Conventional* *Disposable* *Necessary*	$250 allowance, then 15% off balance $250 allowance You pay $0	$200 allowance Up to $160 Up to $200
Additional Discounts	40% off complete SECOND pair of glasses 20% off non-covered items (except safety glasses)	
Important Notes	Allowances based on Date of Service Allowances are Single-use allowance	

Vision Plan Premiums: This is a voluntary plan, meaning you pay 100% of the premiums. Premiums are effective September 1, 2021:

Status	Monthly Rates
Employee only	$9.29
Family	$23.13

Please review your plan summary document for more detailed coverage information.

DELTA DENTAL

Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, you receive an amount that the provider will pay up to. You are then responsible for the difference.

Note: This is a voluntary plan, participation is optional. You may waive this coverage if you don't need eyeglasses or contacts.

QUESTIONS?

Call customer service at **800-236-3712** or call the phone number on the back of your ID card or visit **www.deltadentalwi.com**.

ANCILLARY PLANS

All benefit-eligible employees are enrolled in life insurance and accidental death & dismemberment (AD&D) insurance and Long Term Disability. We pay 100% of the premium for you.

LIFE AND AD&D

This benefit is provided through Reliance Standard. You are covered for 1x your salary up to $200,000 maximum for the basic life plan. You are also covered at the same amount for the AD&D plan. The original amount of the Life and AD&D benefits will reduce as you age and terminate upon your retirement or termination of employment. Now is a great time to review or update your beneficiary.

LONG TERM DISABILITY

This benefit is provided through National Insurance Services. You may receive 90% of your earnings up to a maximum monthly benefit of $10,500 in the event of a qualifying disability claim. Benefits may begin after 60 days or after conclusion of STD benefit. This is a taxable benefit.

SHORT-TERM DISABILITY

This is a voluntary plan, meaning you pay 100% of the premiums. This benefit allows you to purchase a weekly amount that best suits your needs, provided the amount does not exceed 66 2/3% of your weekly predisability earnings. The rate table is below. Enrollment in this benefit is subject to a 12/12 Pre-Existing Condition Exclusion. This means that if you have a disability claim within the first 12 months of enrolling in the plan, NIS will look back 12 months prior to the effective date to see if the condition existed. If the condition did exist, benefits may not be payable. In the event of a qualifying disability claim, benefits begin the 1st day of an accident or the 3rd day of an illness for a maximum of 60 consecutive calendar days. Short Term Disability is provided through NIS.

SHORT TERM DISABILITY
WEEKLY AMOUNTS AND MONTHLY RATES

Weekly Benefit	Monthly Premium
$147.00	$9.98
$175.00	$11.64
$224.00	$14.96
$273.00	$18.28
$301.00	$19.96
$357.00	$23.84
$420.00	$27.72
$462.00	$30.48
$504.00	$33.26

Because you pay the premiums yourself, with after tax payroll deductions, benefits are not taxable to you.

VALUE – ADDED SERVICES

Resources for Your Total Health Support from **National Insurance Services**.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Everyday life can be stressful and can affect your health, well-being and performance. Fortunately, our Employee Assistance Program can aid in finding solutions. When facing personal problems, you might struggle with where to turn for help. The first step is usually the hardest, and guidance is often the key. That's why we offer an EAP. An EAP offers a confidential place to find the answers that work for you. Receive compassionate expertise and confidential help for a variety of health concerns, including:

- Depression
- Alcohol and drug addiction
- Financial or legal concerns
- Stress management
- Child and elder care
- Marital difficulties
- Family conflict

Call **(866) 451-5465** to inquire about EAP services or visit **www.niseap.com**.

FINANCIAL ASSISTANCE

Telephone consultation with a financial consultant to address questions on budgeting, taxes and debt consolidation.

LEGAL ASSISTANCE

Counselors may refer you to a telephone and/or in-person consultation with an attorney.

CHILDCARE AND ELDERCARE ASSISTANCE

Telephone consultation with a work-life professional to provide information, referrals and resources related to childcare or eldercare concerns.

CLAIMANT ASSISTANCE

Our Claimant Assist program offers special services to Long-Term Disability claimants or Life insurance beneficiaries at no charge. If you have Disability insurance coverage through NIS, our Long-Term Disability Claimant Services are available to guide and counsel claimants and their immediate family members.

Claimant Assist services are available at **866-472-2734**.

NEXT STEPS

HEALTH PLAN

If you would like to enroll in the District Health Insurance, change your family status, or change to the Alternate Benefit of Cash in Lieu of Health Insurance Premiums, this is the one time during the year you can do so without a qualifying event. Please contact Shari Berget for an enrollment form.

If you are already enrolled in the health plan, you will be automatically re-enrolled at your current coverage status. No forms are needed.

HEALTH SAVINGS ACCOUNTS

New HSA participants need to complete paperwork to set up an account. If you do not set up the HSA account by the time The School District of Albany's contributions are scheduled to be made, The School District of Albany will not make those contributions. Those amounts will be forfeited and not made later after you have set up the account.

DENTAL PLAN

If you would like to enroll, add, change or drop dependent(s), now is the time you are able to do that. Please contact Shari Berget to make changes. If you are currently enrolled and do not have any changes, you will be automatically re-enrolled at your current coverage status. No forms are needed.

LIFE, AD&D, & LTD PLANS

All benefit-eligible employees are enrolled in these plans. Now is a good time to review your beneficiary designation for your life and AD&D policies.

STD PLAN

To enroll in this plan, forms must be filled out and returned. Evidence of insurability (i.e.: medical history) may be required if you are requesting a weekly benefit amount above the Guarantee Issue, or if you have previously waived coverage. For example: If you wait to apply for the STD plan until after you become pregnant, the result will be a declination of coverage due to the pregnancy being an existing health condition. Please contact Shari Berget for more information.

QUESTIONS? NEED FORMS?

Contact Shari Berget, **608-862-3225 ext. 2410**
shari.berget@Albany.k12.wi.us

CARRIER QUICK LINKS

Health Plan

Dean	**800-718-3326**
	www.deancare.com

Health Savings Account

Associated Bank	**800-270-7719**
	www.associatedbank.com

Dental Plan

Delta Dental	**800-236-3712**
Of Wisconsin	**www.deltadentalwi.com**

Voluntary Vision Plan

Delta Dental	**800-236-3712**
Of Wisconsin	**www.deltadentalwi.com**

Life Plan

Reliance	**800-351-7500**
Standard	**www.reliancestandard.com**

LTD & Voluntary STD Plans

NIS	**800-627-3660**
	www.nisbenefits.com

WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. HIPAA Portability Notice
2. Initial COBRA Notice
3. Notice of Exchange
4. Medicare Part D Coverage Notice
5. CHIP Notice
6. WHCRA Notice

HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company's Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

Special enrollment rights
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 that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 **30 days** after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within **60 days** after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact **Shari Berget 608-862-3225 or shari.berget@albany.k12.wi.us**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse, and dependent children when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the employer.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, and any required notice of that event is properly provided to the employer, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage unless the Plan sponsor has chosen to subsidize the cost of COBRA continuation coverage

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

Your dependent children will be entitled to elect COBRA if they lose group health coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice to: Shari Berget (608) 862-3225 or shari.berget@Albany.k12.wi.us If these procedures are not followed or if the notice is not provided during the 60 day notice period, ALL QUALIFIED BENEFICIARIES LOSE THEIR RIGHT TO ELECT COBRA.

How is COBRA continuation coverage provided?
Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

This extension due to a second qualifying event is available only if you notify the employer in writing of the second qualifying event within 60 days of the date of the second qualifying event. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the individual health insurance carriers, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa** (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Shari Berget
(608) 862-3225
shari.berget@Albany.k12.wi.us

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General information

Since 2014, individuals can purchase health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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 November for coverage starting as early as January 1st.

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.

Does employer health coverage affect eligibility for premium savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit[1].

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact **Shari Berget 608-862-3225 or shari.berget@albany.k12.wi.us** .

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information about health coverage offered by your employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: **School District of Albany**
4. Employer Identification Number (EIN): **39-6000626**
5. Employer address: **400 5th Street**
6. Employer phone number: **(608) 862-3225 ext 2410**
7. City: **Albany**
8. State: **WI**
9. ZIP code: **53502**
10. Who can we contact about employee health coverage at this job? **Shari Berget**
11. Phone number (if different from above): **Same as above**
12. Email address: **shari.berget@Albany.k12.wi.us**

Here is some basic information about health coverage offered by this employer
As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees: Eligible employees are: those scheduled to work 30 hours or more.

With respect to dependents:

☒ We do offer coverage.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

MEDICARE PART D CREDITABLE/NON-CREDITABLE COVERAGE NOTICE

Important notice from The School District of Albany about your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The School District of Albany has determined that the prescription drug coverage offered by Dean Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

What happens to your current coverage if you decide to join a Medicare drug plan?
If you decide to join a Medicare drug plan, your current School District of Albany will not be affected.

If you do decide to join a Medicare drug plan and drop your current School District of Albany coverage, be aware that you and your dependents may not be able to get this coverage back right away or at all. Please review the School District of Albany health plan documents for details regarding eligibility and enrollment rights.

When will you pay a higher premium (Penalty) to join a Medicare drug plan?
You should also know that if you drop or lose your current coverage with The School District of Albany and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage…
Contact the person listed on the next page for further information.

NOTE: You'll get this notice each year. You will also get this notice if the coverage through The School District of Albany changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	09/01/2021
Name of Entity/Sender:	School District of Albany
Contact--Position/Office:	Shari Berget - District Bookkeeper
Address:	400 5th St., PO Box 349, Albany, WI 53502
Phone Number:	608-862-3225 ext. 2410

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 **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 **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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: Health Insurance Premium Payment (HIPP) Program **http://dhcs.ca.gov/hipp** Phone: 961-445-8322 Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid – Medicaid and CHIP (Hawki)**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
INDIANA – Medicaid	**LOUISIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	NEVADA – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Main relay 711	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MINNESOTA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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
MISSOURI – Medicaid	**NEW YORK – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MONTANA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NEBRASKA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855 632-7633 Lincoln: 402 473-7000 Omaha: 402 595-1178	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women's Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women's Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the company's health insurance carrier directly for more information on your rights under the Women's Health and Cancer Rights Act.

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This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

Your employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.

Information provided by USI Insurance Services.