MESA
PUBLIC SCHOOLS

Mesa Public Schools
2012/2013
Benefits and Enrollment Guide

Inside:

MESA
PUBLIC SCHOOLS

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MPS employees,

Thank you for your dedicated service to Mesa Public Schools. Open enrollment provides you the opportunity to choose the best benefit options for yourself and your family.

As a part of MPS, you have numerous benefits available to you. This year, we welcome Cigna as our new service provider for medical benefits. You continue to have a choice of medical plans, including two high-deductible health plans and one traditional EPO plan. In addition, we offer plans that provide coverage for dental, vision, short- and long-term disability, long-term care, a flexible spending account, automobile insurance, pet care insurance and more.

When selecting a health care plan, carefully consider the needs of you and your family. Review the information and materials available and attend the open enrollment meetings. Take an active role in this process so you can get the most out of your benefit options by choosing the plan and coverage that best protect you and your loved ones. Remember, one plan is not better than another; each plan simply offers different benefits.

Mesa Public Schools is proud to be a vital part of the Mesa community. One reason we are an employer of choice is the rich benefit package we offer eligible employees. MPS is pleased to offer a variety of benefits to our dedicated employees, and I hope you take advantage of this opportunity.

Sincerely,

Michael B. Cowan

Dr. Michael B. Cowan
Superintendent
Mesa Public Schools

Enrollment Opportunities
You may make benefits elections:

1. when you are hired as a new employee (within 31days),
2. when you have a qualified IRS change mid-year (within 31 days), or
3. during Open Enrollment.

Important – Duplicate Coverage Prohibited
A husband and wife who are both active Mesa Public Schools employees may not enroll as both an employee and a dependent spouse in the same plans. Duplicate coverage is not permitted under the benefits program. Employees are responsible to ensure they and their dependents do not have duplicate district coverage. Duplicate benefits will not be paid.

Making a Change in Your Coverage Mid-Year
Premiums for your medical, dental and vision coverage are taken out of your check before taxes are calculated (known as pre-tax), increasing your spendable income and reducing the amount you owe in income taxes. Plans that pre-tax their benefits must follow Internal Revenue Service (IRS) tax laws. These laws require that once benefits are elected, you must stay in the plans you selected for a full plan year (October through September). You can only make changes to your benefits during open enrollment or if you have a special enrollment event or qualifying mid-year change event. If you experience a qualified IRS change mid-year, you may be permitted to make a change provided the change is permitted by the IRS and your change request occurs within 31 days of the event. If the change request is not completed within 31 days of the event, you will not be able to change your elections until the following year's annual benefits open enrollment period.

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

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

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

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

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

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

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

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

***REMINDER**: After the open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a special enrollment event or a mid-year change in status as outlined above.*

Special Note for Missed Premiums

If you miss any premium deductions because of an unpaid absence or leave, you must pay all missed premiums or your coverage will be cancelled for the remainder of the plan year. Missing one or two pay periods is considered a short term leave of absence. Please review the policy in the Continuation of Coverage section. The Employee Benefits Department will either adjust your deductions for the remaining pay periods or bill you for missed premiums. The payment deadline is strictly enforced.

If you miss a deduction, please contact your district Benefits Specialist immediately so that the Employee Benefits Department can calculate your share of the premiums due. This must be done so that your benefits continue without interruption for the remainder of the plan year. If your benefits are cancelled for non-payment of premiums, you will be permitted to re-enroll only during the next Open Enrollment period.

Refunds

- If you pre-paid for medical, dental, vision or life insurance coverage benefits, and are terminated prior to the end of the plan year, a refund of the pre-paid premiums will be given.
- Refunds (other than for termination) will only be considered when an administrative error by the district has occurred. Errors by members will not be considered. The member must submit a request within one calendar year of the administrative error, and a refund will only be approved for up to a one-year period. A refund request for any reason other than an administrative error by the district cannot be approved. Examples of refund requests that will be denied include:
  - An incorrect coverage level due to:
    - Dependent no longer being eligible
    - Divorce
  - Incorrect benefits due to errors on your enrollment form
  - Incorrect deductions for changes that were not made within 31 days of the qualifying change in status
  - If benefits were used during the period in which a refund is being requested, no refund is permitted

Medical Plan Choices

MPS offers three medical plan options. Make certain you carefully review and compare each plan to determine which best meets the needs of you and your family. Following are the medical plan options:

1. EPO (OAP Copay Plan) 2. Cigna Choice HDHP $1,500 w/ HSA 3. Cigna Choice HDHP $2,500 w/ HSA

A Closer Look at Your Medical Plan Options

	EPO (Cigna OAP Copay Plan)	HDHP 1500 (Cigna Choice Plan)		HDHP 2500 (Cigna Choice Plan)	
	In-Network only** You pay:	In Network	Out of Network	In Network	Out of Network
Annual Deductible					
For employee only	$350	$1,500	$3,000	$2,500	$5,000
For employee + 1	$700				
For employee + family	$1,050	$3,000	$6,000	$5,000	$10,000
Out-of-Pocket Maximum					
For one person	$2,000 per person (applies to inpatient hospital coinsurance only)	$3,000	$6,000	$2,500	$5,000
For your family of 2 or more		$6,000	$12,000	$5,000	$20,000
Doctor's Office Visits	PCP $20 co-pay/visit Specialist $35 co-pay/visit	80%*	60%*	100%*	50%*
Urgent Care	$35 co-pay/visit	80%*	60%*	100%*	50%*
X-rays, lab work	$0*	80%*	60%*	100%*	50%*
Doctor's Office or outpatient facility	$0	80%*	60%*	100%*	50%*
Well Child Care	$0	100%	Not covered	100%*	Not covered
Well Women Care	$0	100%	Not covered	100%*	Not covered
Adult Preventive Care	$0	100%	Not covered	100%*	Not covered
Immunizations	$0	100%	Not covered	100%*	Not covered
Hospital Care (Inpatient)	$150 co-pay per admission You pay 20% up to $2,000*	80%*	60%*	100%*	50%*
Emergency room	$100 copay*	80%*	80%*	100%*	100%*
Ambulance service	$0*	80%*	60%*	100%*	50%*
Outpatient Surgery					
Professional Fees	$0*	80%*	60%*	100%*	50%*
Facility Fees	$150 co-pay*	80%*	60%*	100%*	50%*
Outpatient Physical/Speech and Occupational Therapies up to a combined 50 visits per calendar year	$20 or 35 co-pay per visit*	80%*	60%*	100%*	50%*
Prescription Drugs (Outpatient)					
Annual outpatient prescription drug (Rx) deductible per person	$100 annual deductible per person.	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***	Combined medical and pharmacy deductible. Deductible must be satisfied before coinsurance applies***

	EPO (Cigna OAP Copay Plan)	HDHP 1500 (Cigna Choice Plan)		HDHP 2500 (Cigna Choice Plan)	
	In-Network only You pay:**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
30-day supply (retail)*	Generic - $7 co-pay Preferred Brand - $15 co-pay Non-preferred Brand - 40% to a maximum of $100	80%*	60%*	100%*	50%*
90-day supply (mail order)*	Generic - $14 co-pay Preferred Brand - $30 co-pay Non-preferred Brand - 40% to a maximum of $200	80%*	Not covered	100%*	Not covered
Mental Health and Substance Abuse Treatment					
Inpatient	$150 co-pay per admission You pay 20% up to $2,000*	80%*	60%*	100%*	50%*
Outpatient	PCP $20 co-pay/visit Specialist $35 co-pay/visit	80%*	60%*	100%*	50%*
EAP Visits	EAP Preferred 8 visits - $0	EAP Preferred 8 visits - $0	Not covered	EAP Preferred 8 visits - $0	Not covered

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

The chart above does not provide a complete list of covered services. Please see your Plan Document for a complete list. If there is any discrepancy between this chart and the Plan Document, the Plan Document will govern. Copies of the Plan documents are on file in the Employee Benefits Department.

Health Savings Account (HSA)

The HSA is available to employees who enroll in one of the High Deductible Health Plans (HDHPs). The HSA can be used for qualified healthcare expenses not paid by any other health plan. Mesa Public Schools will make a contribution to the HSA for all eligible employees enrolled in a HDHP. You may also choose to contribute additional funds to your HSA account. Any contributions you make are deducted from your paycheck on a pre-tax basis. You may change your HSA contribution amount at any time.

To qualify for monetary contributions to an HSA, you:

1. Must be enrolled in a Mesa Public Schools HDHP,
2. Cannot be claimed as a dependent on someone else's tax return,
3. Cannot be covered by a spouse's health care flexible spending account (FSA),
4. Cannot be covered by any other health plan coverage (except what is permitted by the IRS),
5. Cannot be enrolled in Medicare.

Dental Plans

The district offers the choice of two dental plans, TDA A500S DHMO and Cigna PPO. The DHMO plan offers lower rates and no maximum annual limits, but requires you to see dentists in-network unless you are pre-approved and/or there is not a specialist in your service area that can perform the services. The PPO allows you to choose in- or out-of-network providers and has deductibles, coinsurance and maximum annual coverage limits.

Benefit	Total Dental Administrators A500S DHMO Plan You pay:	CIGNA Dental PPO Plan - You Pay:	
	In-Network	In-Network	Out-of-Network
Annual Deductible ■ For one person ■ For your family	 $0 $0	 $25 $75	 $25 $75
Diagnostic and Preventive Services ■ Office visit ■ Oral Exams ■ Cleanings ■ X-rays ■ Fluoride (1 per yr. to age 15)	Scheduled amounts no copays $0 $0 $0 $0 $0	$0 with no deductible	20% of allowed amount plus any charges in excess of the allowed amount, no deductible
Basic Treatment ■ Extractions, simple ■ Sealants (molars-per tooth to age 17) ■ Fillings (amalgam) ■ Fillings (Composite for molars) ■ Root Canal (molar) ■ Periodontics (scaling, root planing) ■ Osseous Surgery	Scheduled amounts $30 $10 per tooth $10 to $37 per tooth $40 to $76 per tooth $395 $90 per quadrant $167 to $390	20% after deductible	20% of allowed amount plus any charges in excess of the allowed amount, after deductible
Major Treatment ■ Crown ■ Full denture (upper or lower) ■ Partial denture (upper or lower) ■ Bridge (3 unit)	Scheduled amounts $270 +$185 lab $300 + $275 lab $375 + $275 lab $270 +$185 lab each unit	50% after deductible	50% of allowed amount plus any charges in excess of the allowed amount, after deductible

Benefit	Total Dental Administrators A500S DHMO Plan You pay:	CIGNA Dental PPO Plan - You Pay:	
	In-Network	In-Network	Out-of-Network
Orthodontia ■ Adults and Children (to age 19)	Scheduled amounts	Not covered	
Additional Benefits ■ Specialist Services ■ General anesthesia (first 30 minutes) ■ TMJ	Scheduled Amounts (Pedodontist & Prosthodontist 20%-25% discount off regular fees) $195 20% below regular fees	20% after deductible Not covered	20% of allowed amount plus any charges in excess of the allowed amount, after deductible Not covered
Annual Maximum	Unlimited	$1,000	
Benefit Provider Choice	Participants must use TDA dentist or specialist	Participants may use an in-network or out-of-network dentist	
Lifetime Orthodontia Benefit ■ Adults and children (to age 19)	Scheduled Amounts	Not covered	

Vision Benefits

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

A Closer Look at Your Vision Benefits

Vision Plan	
Eye Exam payable every:	12 months
Lenses payable every:	12 months
Frames payable every:	24 months
In-Network Vision Provider	
Exam Co-payment:	$15.00
Allowances	
Wholesale frame allowance:	$50.00
Retail frame allowance:	$130.00
Elective contact lenses:	$130.00
Lenses Options:	Polycarbonate lenses for children

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

Flexible Spending Accounts
A Flexible Spending Account (FSA) allows you to use pre-tax dollars to pay for qualified healthcare or dependent day care expenses. Three FSA accounts are available:

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

You determine the amount you want to contribute to an FSA at the beginning of each plan year and you may access these funds throughout the year. All FSA contributions are pre-tax, which means you save money by not paying taxes on the amount you set aside to pay for eligible expenses. The maximum annual amount you can contribute to each flexible spending account is:

- HCFSA - $2,500
- Ltd HCFSA - $2,500 (For individuals enrolled in a HDHP)
- DCFSA - $5,000

Life Insurance Benefits
Basic Life Insurance
As an eligible district employee, you receive basic life insurance at no cost to you. The basic life benefit amount is $50,000 for all full-time eligible employees and $20,000 for eligible half-time and three-fifths employees. You automatically receive the basic life coverage. It is your responsibility to keep your beneficiary designation up to date. If you have eligible dependents, they receive basic dependent life insurance coverage.

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

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

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

Short-Term Disability Plan
You are eligible to enroll in Short-Term Disability (STD) benefits if you work 20 or more hours per week. STD benefits help replace lost income if you cannot work because you are totally disabled due to a non-work accident or illness, including pregnancy. Employees purchase STD coverage based on their salary. STD benefits begin the first day of an accident and on day eight for sickness and pregnancy. The maximum length of STD coverage is 26 weeks. Benefits are paid biweekly and calculated using your weekly salary (less any overtime, bonuses or other forms of extra pay).

Employee Assistance Program
All employees are eligible to receive confidential counseling benefits through the district's Employee Assistance Program (EAP). You and your eligible family members are automatically covered and receive up to 8 counseling sessions at no cost to you. The EAP provides confidential, personal assessments, and referral services through ***EAP Preferred***. You can **confidentially discuss** your situation and find resources and information for personal difficulties such as:

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

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

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

- Long-term care insurance
- Group auto insurance
- Pet insurance

FOR HELP OR INFORMATION

When you need information, please refer to this document first. If you need further help, call the contacts listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Medical Plans Claims Administrator • Claim Forms (Medical) • Medical Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • HIPAA Certificate of Creditable Coverage	**Cigna Healthcare Customer Service** 1-800-Cigna24 or 1-800-244-6224 Website: www.cigna.com or www.mycigna.com Claim Submittal Address/Appeal Submittal Address: Cigna Healthcare P. O. Box 182223 Chattanooga, TN 37422 MPS Group Number: 3333634
Prescription Drug Plan • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Direct Member Reimbursement (for non-network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering	**Cigna Healthcare Customer Service:** 1-800-Cigna24 or 1-800-244-6224 **Cigna Home Delivery** Customer Service: 1-800-285-4812 Specialty Drug Customer Service: 1-800-835-3784 Cigna Home Delivery P.O. Box 109 Horsham, PA 19044 Website: www.cigna.com or www.mycigna.com
Employee Assistance Program (EAP) • Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.	**EAP Preferred** *Live Support: 24 hours/7 days* 1-800-327-3517 or 602-264-4600 www.eappreferred.com Enter username: MESAUSD Enter password: eappreferred
Behavioral Health Program **for all medical plans** • Mental Health and Substance Abuse Services and Providers • Precertification of Certain Behavioral Health Services • Behavioral Health Claims and Appeals	**Cigna Healthcare Customer Service** 1-800-Cigna24 or 1-800-244-6224 www.cignabehavioralhealth.com
Dental PPO Plan • Dental Network Provider Directory • Dental Claims and Appeals	**CIGNA Dental PPO** Customer Service: 1-800-244-6224 www.mycigna.com

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Dental A500S DHMO Plan • The insured Dental A500S plan benefits are briefly described in this document. Contact the Employee Benefits Office for further information.	**Total Dental Administrators** Customer Service: 602-266-1995 or 888-422-1995 www.TDAdental.com
Vision Plan • Vision Network and Provider Directory • Vision Claims and Appeals	**Vision Service Plan (VSP)** Customer Service: 1-800-877-7195 www.vsp.com
Health Savings Account (HSA) Bank	**Cigna Healthcare Customer Service** 1-800-Cigna24 or 1-800-244-6224 Website: www.cigna.com or www.mycigna.com
Life Insurance • The life insurance benefits are not fully described in this document. Contact the Employee Benefits Department for further information.	**Sunlife** 1-800-247-6875 Website: www.sunlife.com/us
FSA Claims Administrator • Health FSA - both General Purpose and Limited Purpose for HDHP participants • Dependent Care FSA	**Allegiance Flex Advantage (a Cigna company)** Customer Service: 1-877-424-3570 Fax: 1-877-424-3539 www.allegianceflexadvantage.com
Benefits Online Enrollment	**BenefitFocus** 1-877-336-8082 www.mpsaz.hrintouch.com

IMPORTANT NOTICES

Notice of MPS Privacy Practices

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

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

To obtain a copy of this Plan's HIPAA Notice of Privacy Practice for the above noted group health plan benefits, write or call the Employee Benefits Department at 63 E. Main Street #101, Mesa AZ 85201-7422, (480) 472-7222 or access your benefits website at www.mpsaz.org/eb.

Women's Health and Cancer Rights Act (WHCRA)

Your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, refer to your medical Plan Document or call the Employee Benefits Department at (480) 472-7222.

Newborn's and Mother's Health Protection Act

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

Unemployment Insurance

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

Workers' Compensation

If you have a job-related illness or injury that requires medical care (beyond first aid) and/or requires you to take time off from work, you may file a claim for Workers' Compensation benefits. You may obtain an Employee Claim for Workers' Compensation benefits form from your supervisor at your work site. Arizona Workers' Compensation Law provides compensation benefits for employees who have a job-related illness or injury. Those benefits may be less than the total wages an employee would otherwise earn. Your district-sponsored healthcare benefits will continue for as long as you are off work through an approved FMLA leave or you continue to receive any part of your salary from the district. If you are off work through a non-FMLA leave and you do not receive any salary from the district, your district-sponsored benefits will end, and you will receive a notice to pay premiums under COBRA if you want to continue health coverage. This rule applies even if you are still receiving temporary disability payments under Workers' Compensation. For more information, please call the District Workers' Compensation office at (480) 472-0366.

Reasonable Accommodations for Individuals with Disabilities

The district is committed to providing equal employment opportunities for individuals with disabilities and does not discriminate on the basis of a disability in the admission, access, treatment or employment in its programs or activities. The district has established a return-to-work program to assist injured and/or ill employees in continuing gainful, productive and rewarding employment. For additional information about reasonable accommodations, please contact the Risk Management Department at (480) 472-0365.

Qualified Medical Child Support Order

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

Uniformed Service Employment and Reemployment Rights Act (USERRA)

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

If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services for more than 31 days. The employee will be offered the opportunity to

elect temporary coverage under COBRA or USERRA. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

Health Care Reform

Health care reform has arrived, but research indicates that most Americans - employers and employees alike - have a limited understanding of what the changes mean for them. As everyone scrambles to understand how the new law will affect them, one thing is certain - the reform has an immediate and future affect on the Mesa Public Schools benefit provisions, program administration and costs.

The new health care reform law, called the Affordable Care Act, requires group health plans to implement new provisions to their medical plans. These provisions were effective for our MPS medical plans on October 1, 2010 and included the following changes:

- Removed lifetime or annual limits on the dollar value of essential health benefits
- Allowed coverage for dependent children to the age of 26

On October 1, 2011, the Plan made the following changes to help comply with health reform:

- Removed the pre-existing condition limitation
- Enhanced preventive care benefits
- Enhanced coverage for emergency room services out-of-network
- Added a voluntary external review option during the process of appealing a claim

If you are a benefits-eligible employee and not currently enrolled in the MPS medical plan, you have the opportunity to enroll during the open enrollment period, along with your eligible spouse and children. Note that an employee's grandchildren, child under a legal guardianship, foster child, son-in-law, and daughter-in-law are not eligible for coverage under the plan.

To enroll, you must complete the online Benefits enrollment within the designated enrollment opportunity. For more information, contact the Employee Benefits Department.

Patient Protection Rights Affordable Care Act

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

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

Information on Employee Fraud and Abuse

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

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

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

- Lock-down of your prescription benefits to only one doctor or pharmacy,

- Termination of coverage, or
- Restitution for any claims/benefits that were inappropriately paid.

Serious criminal or civil consequences may result.

Notice About Disclosure and Use of Your Social Security Number

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

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

General Notice of Continuation of Coverage (COBRA) Rights

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

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

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

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

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

Leave/Continuation of Coverage/COBRA

While on Leave of Absence

If you take a Leave of Absence Without Pay (LAW) you may continue the same health benefits coverage during the leave by paying the full cost of your premiums. If you take a leave of absence pursuant to the Family Medical Leave Act (FMLA), special rules govern the continuation of your health benefits. You have several options for your health benefits coverage while you are on FMLA leave, including whether to keep your coverage in place or drop it and how to pay for health benefits coverage while you are on FMLA leave. You should review the options and make an informed decision. Contact your Agency Benefits Coordinator for details, and visit the Employee Benefits Department website.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families *Required notice*

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can contact your state Medicaid or CHIP office, call **1-877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is a special enrollment opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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, 2011. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
GEORGIA – Medicaid	**MISSOURI** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO –** Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.dmas.virginia.gov/rcp-IPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if additional states have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

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

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

OMB Control Number 1210-0137 (expires 09/30/2013)

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