Mesa Public Schools

2020-2021 Benefits and Enrollment Guide

Inside:

Benefits Information

Health Plan Comparisons

Benefit Program Descriptions

Contact Information

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Benefits Guide

Welcome!

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

What's New for 2020-2021?

- The plan year will run from **July 1, 2020 – June 30, 2021**. Your Deductibles and Out-Of-Pocket amounts will reset **July 1**.
- No increase to Employee premiums for medical, dental and vision.
- Increase to Employee premiums for Sun Life Supplemental Life Insurance.
- Implement Patient Assurance Program to limit member out-of-pocket costs for insulin to $25 max per 30-day supply, and $75 per 90-day supply.
- **OAP plan** will have two-tiered copay structure to incentify utilization of Cigna Care Designated (CCD) providers: CCD PCP: $20 Specialist $30
- **OAP plan:** reduced telehealth copay from $30 to $15
- HSA District contribution will be **One Lump Sum** in September. (Employees should review their total contributions (including District contributions) and make any adjustments to ensure they do not exceed 2020 IRS annual contribution limits)
- **Dental PPO plan:** Remove accumulation of Class I services from the annual maximum ensuring members will have access to annual cleanings
- Increase Retail Frame Allowance from $130 to $180 for VSP vision insurance
- Life Insurance Special Enrollment – Ongoing employees may choose the lesser of up to two times their annual salary or up to $250,000 for supplemental life insurance for themselves, up to $50,000 for Spouse Supplemental Life, and up to $15,000 for Child Supplemental Life without completing an Evidence of Insurability (EOI).

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

Thank you for your dedicated service to Mesa Public Schools.

HOW TO ENROLL

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

Have Questions?

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

If your last name starts with:

A- K

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

L- Z

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

WHEN CAN I ENROLL?

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

- when you are hired as a new, benefits-eligible employee—you must enroll **within 31 days* of your hire date.**
- when you transfer to a benefits-eligible position mid-year you must enroll **within 31 days* of your date of transfer to the new position.**
- when you have a qualified mid-year change event (including a Special Enrollment opportunity), you must enroll **within 31 days*** of the event (60 days for a Medicaid/CHIP event).
- during Open Enrollment when you are benefits-eligible (April 21 – May 7).

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

* *Note that the District will consider the date of the event as the first day for purposes of counting towards the 31-day deadline.*

WHAT IF I MISS THE DEADLINE?

- **As a New Hire/Transfer**—You will only have Basic Life Insurance. You will have to wait until the next Open Enrollment period (unless you have a Special Enrollment opportunity or a permitted mid-year change in status event, described below).
- **During Open Enrollment**—Your current benefits will continue, except for the Flexible Spending Accounts or Dependent Care Flexible Spending Account. Flexible Spending Accounts or Dependent Care Flexible Spending Account must be elected every year.

Premiums

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

Refunds

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

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

Mid-Year Permitted Election Change Event:

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

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

- Change in legal marital status (e.g., marriage, divorce/legal separation, dependent's death)
- Change in number or status of dependents (e.g., birth, adoption, dependent's 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
- If an employee is covered by a District-sponsored medical plan and the employee is eligible to enroll in the Health Insurance Marketplace during its Open enrollment or Special enrollment period, the employee can request to be dropped from the medical plan to go enroll in the Health Insurance Marketplace.

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

* *Note that the District will consider the date of the special enrollment event as the **first day for purposes of counting towards the 31-day special enrollment deadline**.*

Special Enrollment Event

- **Loss of Other Coverage Event:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for the other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **within 31 days** ** **of the date** you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).
- **Marriage, Birth, Adoption Event:** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment **within 31 days** ** **of the date** of the marriage, birth, adoption or placement for adoption.
- **Medicaid/CHIP Event:** You and your dependents may also enroll in this plan if you (or your dependents):
  - have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
  - become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

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

** *Note that the District will consider the date of the special enrollment event as the **first day for purposes of counting towards the 31-day special enrollment deadline**.*

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

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MEDICAL PLAN CHOICES

For 2020-2021 our plan year will be **July 1, 2020 through June 30, 2021**. Mesa Public Schools will continue to provide three medical plans through CIGNA. Each plan option are high-quality options, with the same services and network. Make certain you carefully review and compare each plan to determine which best meets the needs for you and your family. Have questions about the medical plans call **Cigna's Pre-Enrollment Hotline 1-888-806-5042**.

Below is a summary of the medical plans. For a more complete schedule of medical benefits please see your Plan Document. You may request a copy from the Employee Benefits Department or view online at www.mpsaz.org/benefits.

Highlights of the Medical Plan Options Offered by Mesa Public Schools

	OAP (Cigna OAP Copay Plan)	HDHP 1500 w/HSA (Cigna Choice Plan)		HDHP 2500 w/HSA (Cigna Choice Plan)	
	In-Network only** You Pay:	In-Network You Pay:	Out of Network You Pay:	In-Network You Pay:	Out of Network You Pay:
Annual Deductible					
For employee only	$700	$1,500	$3,000	$2,500	$5,000
For employee + 1	$1,400				
For employee + family	$2,100	$3,000	$6,000	$5000	$10,000
Out-of-Pocket-Limit					
For one person	$4,250	$4,000	$8,000	$3,500	$7,000
For your family of 2 or more	$8,500	$8,000	$16,000	$7,000	$14,000
Doctor's Office Visits	**Tier 1:** Cigna Care Designated (CCD)**** PCP: $20 copay/visit Specialist: $30 copay/visit **Tier 2:** PCP: $30 copay/visit Specialist: $50 copay/visit	20%*	40%*	10%*	50%*
Urgent Care Facility Visit	$60 copay/visit	20%*	40%*	10%*	50%*
X-rays, lab work Outpatient facility	$0*	20%*	40%*	10%*	50%*
Doctor's Office	Office visit copay applies except for preventive care	20%*	40%*	10%*	50%*
Well Child Care	$0	0%	Not covered	0%	Not covered
Well Women Care	$0	0%	Not covered	0%	Not covered
Adult Preventive Care	$0	0%	Not covered	0%	Not covered
Immunizations	$0	0%	Not covered	0%	Not covered
Hospital Care (Inpatient)	$300 copay per admission, then you pay 20%*	20%*	40%*	10%*	50%*
Emergency room (ER) visit	$250 copay per visit*	20%*	20%*	10%*	10%*
Ambulance service	$0*	20%*	20%*	10%*	10%*
Outpatient Surgery					
Professional Fees	$0*	20%*	40%*	10%*	50%*
Facility Fees	$250 copay*	20%*	40%*	10%*	50%*
Outpatient Physical, Speech and Occupational Therapies up to a combined 50 days per calendar year	$50 copay per visit*	20%*	40%*	10%*	50%*
Mental Health & Substance Abuse Treatment					
Inpatient	$300 copay per admission, then you pay 20%*	20%*	40%*	10%*	50%*
Outpatient	$30 copay/visit	20%*	40%*	10%*	50%*
EAP Visits	EAP Preferred 8 visits - $0	EAP Preferred 8 visits - $0	Not covered	EAP Preferred 8 visits - $0	Not covered

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

* *After Deductible.*
** *There is no out-of-network coverage for the OAP Copay Plan, except for emergency services.*
*** *Preventive medications on Cigna's Core list are covered at 100% and not subject to deductible.*
**** *Cigna Care Designated (CCD) providers see page (8) for instructions on how to find a CCD provider*

RATES PER PAY PERIOD *(For Benefits Effective 07/01/2020)**

OAP Medical (Cigna OAP Copay Plan)	Employee Monthly Contribution	Employee Contribution (Less than 12-month contract - 20 pay periods)	Employee Contribution (12-month contract - 24 pay periods)
Employee Only	$67.17	$40.30	$33.58
Employee & Spouse	$775.43	$465.26	$387.71
Employee & Child(ren)	$655.97	$393.58	$327.98
Employee & Family	$1,096.10	$657.66	$548.05
HDHP 1500 (Cigna Choice HDHP 1500 Plan)			
Employee Only	$11.20	$6.72	$5.60
Employee & Spouse	$605.70	$363.42	$302.85
Employee & Child(ren)	$505.40	$303.42	$252.70
Employee & Family	$874.87	$524.92	$437.44
HDHP 2500 (Cigna Choice HDHP 2500 Plan)			
Employee Only	$11.20	$6.72	$5.60
Employee & Spouse	$539.80	$323.88	$269.90
Employee & Child(ren)	$450.62	$270.37	$225.31
Employee & Family	$779.10	$467.46	$389.55

* *If your benefits are effective after 07/1/2020, your rate will be prorated contact the Benefits Office for more details .*

PHARMACY UPDATE

All specialty drugs will be filled through the Home Delivery Pharmacy only (including first fill) and limited to 30 days.

Telehealth

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

Telehealth Rates

Plan	OAP	HDHP 1500 / HDHP 2500
Amwell	$15/copay	$55
MDLive	$15/copay	$55

DID YOU KNOW

Healthy Pregnancies, Healthy Babies program is designed to help you and your baby stay healthy during your pregnancy and in the days and weeks after your baby's birth. You will be eligible to receive a $250 gift card if you enroll in the first trimester and $125 if you enroll in the second trimester.

MYCIGNA APP

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

Reminder: Anytime Service at Cigna
Did you know CIGNA ONE GUIDE is available 24 hours a day/7 days a week? You can speak to a live agent to assist you with understanding your plan, get care and get the most out of your plan.

omada® for Cigna®

For eligible Mesa Public Schools employees and their covered dependents

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HEALTHY HABITS, BUILT OVER TIME

Based on behavioral medicine and scientifically tested, Omada® is designed to build healthy habits that last.[1]

- **EAT HEALTHIER**
  Learn the fundamentals of making smart food choices.
- **INCREASE ACTIVITY**
  Discover easy ways to move more and boost your energy.
- **OVERCOME CHALLENGES**
  Gain skills that allow you to break barriers to change.
- **STRENGTHEN HABITS**
  Zero in on what works for you, and find lasting motivation.
- **STAY HEALTHY FOR LIFE**
  Get an additional eight months of tips, strategies and support.

MORE GREAT NEWS:

If you or your covered dependents are at risk for type 2 diabetes or heart disease, and enrolled in our Cigna health plan, Mesa Public Schools will cover the entire cost of the program.

Take Omada's 1-minute health screener to see if you're eligible:

omadahealth.com/mpsaz

YOU'LL GET YOUR OWN:

- Interactive program
- Wireless smart scale
- Weekly online lessons
- Professional Omada health coach
- Small online group of participants

[1] References available; contact the Omada Medical Affairs team

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IT'S EASY TO FIND QUALITY PROVIDERS AND HOSPITALS.

You just have to know where to look.

Choosing a health care provider can be stressful. But with our Cigna Care Designation (CCD) and Centers of Excellence (COE) programs, we make it easier. We identify higher-performing* providers and hospitals based on their proven quality of care and cost efficiency. Then, we mark them with a symbol in our provider directory so they're easy to find.

Cigna Care Designation providers

Cigna reviews primary care providers (practitioners, internists and pediatricians), as well as providers in 18 common specialties, including cardiology, dermatology and general surgery. Those who meet Cigna requirements for both care quality and cost efficiency receive the CCD.

Centers of Excellence hospitals

Cigna also reviews how successful a hospital is in treating 18 common conditions, such as heart conditions and procedures, hip replacements and surgeries. When hospitals meet program criteria for cost and proven care effectiveness for a reviewed procedure or condition, they earn the status of a COE for that condition or procedure. Our ratings are based on actual patient outcomes, average lengths of stay and average costs we've gathered from outside sources.

Choose with confidence.

To find a CCD provider:

- Log in to **myCigna.com** or the myCigna® App and select "Find Care & Costs"
- Enter your search information
- Look for the CCD symbol under the provider's name

To find a COE hospital:

- Log in to **myCigna.com** or the myCigna App and select "Find Care & Costs"
- Select "Locations" and type "Center of Excellence" in the search box to see a list of COE hospitals and related procedures
- Look for the COE symbol under the hospital name when searching by procedure

IMPORTANT NOTE:

The listing of a provider in the **Cigna.com** directory does not guarantee that the provider participates in your specific health plan network. To confirm if a provider is in-network for your plan, use **myCigna.com** or the myCigna App. You can also call Cigna customer service at the number on your Cigna ID card.

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company or its affiliates.

*Providers and hospitals identified as having top results based on Cigna's quality and cost-efficiency methodologies. Quality designations, cost-efficiency and other ratings reflect a partial assessment of quality and cost efficiency and should not be the sole basis for decision making. They are not a guarantee of the quality of care that will be provided to individual patients. You are encouraged to consider all relevant factors and consult with your physician when selecting a provider or hospital. Providers and hospitals are independent contractors solely responsible for care delivered; providers and hospitals are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

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HEALTH SAVINGS ACCOUNT (HSA)

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

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

How do I qualify?

To be eligible to open an HSA you must be covered by an HSA-qualified health plan (a HDHP) **and must not be covered by other health insurance that is not an HSA-qualified plan.** (certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance).

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

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

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

The plan administrator does not provide tax advice and no inference may be made that the information contained here constitutes tax advice. The tax information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances.

What happens after I enroll?

An account will be set up and Mesa Public Schools will contribute up to $1,500* ($125 per month of eligibility) for the HDHP2500 and up to $1,000* ($83.33 per month of eligibility) for the HDHP1500 for all eligible employees enrolled in a HDHP. **Funds will be distributed in one lump sum in September. Employees should review their total contributions (including District contributions) and make any adjustments to ensure they do not exceed 2020 IRS annual contribution limits.**

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

Health Savings Contribution Limits	
	2020
Health Savings Contribution Limits (Employer + Employee)	Self-Only: $3,550 Family: $7,100
Health Savings Catch-up contribution (age 55 or older)	$1,000

* *This contribution amount is if your benefits are effective 07/1/2020; contribution amount will be prorated after effective date of 7/1/2020. Contact the Benefits Office for more details.*

Can I change my Contribution?

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

What happens if I leave the district?

The funds are yours to use for qualified expenses. HSA Bank will convert your account to a non-group account and send you a new HSA card with a Visa logo. You will be responsible for any fees that HSA Bank charges to have the account.

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WELLNESS INCENTIVE PROGRAM

July 1, 2020 - June 30, 2021

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

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

All employees and spouses on the medical plan are eligible to participate. Those who have earned 300 points by June 30, 2021 will be entered into the grand prize drawing for one of three $1,000 gift cards.

Check your point status on **mycigna.com** by simply logging in and selecting "Incentive Awards" under the "Wellness" heading.

Goal	Description	Points
Complete your personalized health assessment	Go to mycigna.com, select "My health assessment" underneath the "Wellness" heading and complete it with your biometric numbers. This is a confidential questionnaire that asks you about your well-being and provides a personalized assessment of your current health and should take less than 10 minutes to complete.	100
Complete a personalized biometric screening	Know your numbers. Work with your healthcare provider to complete your screening for blood pressure, cholesterol, blood sugar and body mass index (BMI). Submitted via claims, Quest, or onsite screening.	100
Telephonic Coaching: Talk to a coach and achieve a health goal	Work one-on-one with a health coach on a health goal. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits – Tobacco Cessation	Quitting tobacco is one of the most important things you can do for better health. A health coach can help you take that critical step today. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits - Weight	If you're looking to get to your healthy weight, a health coach can set realistic goals and help you work toward achieving each one. Automatically updated by coach.	100
Telephonic Coaching: Get help improving my lifestyle habits - Stress	Lower your stress levels and raise your happiness levels by creating a personal stress management plan with a health coach. Automatically updated by coach.	100
Telephonic Coaching: Achieve a goal to overcome a chronic health problem	Work one-on-one with a health coach on a long-term health problem such as congestive heart failure, depression, diabetes, low back pain, etc. Automatically updated by health coach.	100
Get my preventive well visit (preventive exam)	A preventive exam that's used to reinforce good health, address potential and chronic problems. Verified by claims.	100
Get my annual OB/GYN exam (preventive exam)	A preventive exam that can identify early ovarian and cervical cancers, HPV (human papillomavirus), breast cancer and more. Verified by claims.	100
Get a mammogram (preventive exam)	Breast cancer can be found using mammogram tests. Verified by claims.	100
Get a colon cancer screening (preventive exam)	Colon cancer can be treatable when detected early. Verified by claims.	100
Get a cervical cancer screening (preventive exam)	Pap and HPV tests can detect changes that lead to cervical cancer. Verified by claims.	100
Get a prostate cancer screening (preventive exam)	A prostate screening can detect changes that lead to prostate cancer. Verified by claims.	100
Earn 1,000 SmartDollar points	Participate in the step-by-step plan with SmartDollar platform to reach your financial goals. Once you earn 1,000 points, log in to mycigna.com and self-report your success.	100
Complete 9 lessons of the 16-week Cigna Diabetes Prevention Program	Omada is a digital lifestyle change program that inspires healthy habits that last. Must be accepted into the program. Automatically updated.	100
Reduce your weight by 5% with the Cigna Diabetes Prevention Program	Reduce your start weight by 5%. Losing 5 percent or more of your body weight can lower your risk of cancer, heart disease, stroke, and diabetes. Automatically updated.	100
Complete a preventive dental cleaning	You should see your dentist at least once per year for a free exam to check for any problems in the teeth or gums. After your cleaning, log in to mycigna.com and record your exam date.	100

Get started with telephonic health coaching by calling 1.855.246.1873 today!

* If you have an impairment or disability that makes you unable to participate in any of the program events, activities or goals, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards, contact 1.800.Cigna24.

This is an entirely voluntary program; however, employees who choose to participate in the wellness program may receive an incentive of a monetary amount or a wellness prize item that will be identified and communicated during any and all health campaigns.

DENTAL PLANS

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

The **Cigna CARE DHMO** plan requires you to see In-Network dentists and offers lower rates and no maximum annual limits. If you are a new subscriber: **You must elect a provider by calling Cigna before using any services.** If you are **a current subscriber** and would like to change your provider, please call Cigna at 1-800-244-6224.

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

Highlights of the Dental Plan Options Offered by Mesa Public Schools

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

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Rates Per Pay Period *(For Benefits Effective 07/01/2020)**

CIGNA Dental HMO	Employee Monthly Rate	Employee Contribution (Less than 12-month contract - 20 pay periods)	Employee Contribution (12-month contract - 24 pay periods)
Employee Only	$0.00	$0.00	$0.00
Employee & Spouse	$12.03	$7.22	$6.01
Employee & Child(ren)	$14.97	$8.98	$7.49
Employee & Family	$17.63	$10.58	$8.82
CIGNA Dental PPO	**Employee Monthly Rate**	**Employee Contribution** (Less than 12-month contract - 20 pay periods)	**Employee Contribution** (12-month contract - 24 pay periods)
Employee Only	$28.39	$17.03	$14.19
Employee & Spouse	$74.22	$44.53	$37.11
Employee & Child(ren)	$76.76	$46.06	$38.38
Employee & Family	$94.50	$56.70	$47.25

** If your benefits are effective after 07/1/2020 your rate will be prorated contact the Benefits Office for more details*

TIP

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

VISION BENEFITS

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

Benefit Description Vision Plan	
Eye Exam payable every: KidsCare: Children have two exams	12 months
Lenses payable every:	12 months
Frames payable every: KidsCare: Frames for Children	24 months 12 months
In-Network Vision Provider	
Exam Copayment:	$15.00
Allowances	
Wholesale frame allowance:	$100.00
Retail frame allowance:	$180.00
Elective contact lenses:	$130.00
Lens Options:	Single vision, lined bifocal and lined trifocal lenses, as well as polycarbonate lenses for children, are included in prescription glasses. Progressive lenses will incur an additional copay (see Benefits website for details).

Learn more about your vision coverage at vsp.com.

- Find a VSP doctor call VSP at 1-800-877-7195
- Visit **www.vsp.com** and click on the Members tab.
- Sign up for a user account and get the most out of your benefits when you log in-view your personalized benefits, look at your claim history, and much more.

vsp Vision care for life

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

Rates Per Pay Period *(For Benefits Effective 07/01/2020)**

VSP	Employee Monthly Rate	Employee Contribution (Less than 12-month contract - 20 pay periods)	Employee Contribution (12-month contract - 24 pay periods)
Employee Only	$0.00	$0.00	$0.00
Employee & Spouse	$7.50	$4.50	$3.75
Employee & Child(ren)	$6.33	$3.80	$3.17
Employee & Family	$10.87	$6.52	$5.44

** If your benefits are effective after 07/1/2020 your rate will be prorated contact the Benefits Office for more details*

FLEXIBLE SPENDING ACCOUNTS

If you want the FSA, YOU MUST ENROLL IN THESE ACCOUNTS EVERY YEAR.

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

Three FSA accounts are available. During our 2020-2021 plan year, FSA maximum contribution limits are as follows:

- General Purpose Healthcare FSA – HCFSA – (For individuals not enrolled in a HDHP) used to pay eligible medical, dental and vision expenses - $2,600 annual maximum
- Limited use Healthcare FSA - Ltd-HCFSA - (For individuals enrolled in a HDHP) – used to pay eligible dental and vision expenses only - $2,600 annual maximum
- Dependent care FSA – DCFSA – used to reimburse eligible day care, childcare and elder care expenses - $5,000 annual maximum.

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

LIFE INSURANCE BENEFITS

Life insurance provides the people you love with financial support when you can not be there - and when they need it most.

Sun Life Financial

Basic Life Insurance

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

Supplemental Life Insurance

You may choose supplemental life insurance coverage in $10,000 increments up to a maximum of $500,000. Newly eligible employees may choose the lesser of up to four times your annual salary in guaranteed coverage or up to $500,000 (without completing an Evidence of Insurability form). If you select coverage greater than four times your annual salary for yourself, you must complete and submit an Evidence of Insurability form to be approved by Sun Life. **During the 2020-2021 Open Enrollment, Ongoing employees** may choose the lesser of up to two times their annual salary or up to $250,000 (without completing an Evidence of Insurability). To view new rates please visit **mpsaz.org/benefits**.

Supplemental Spouse Life Insurance

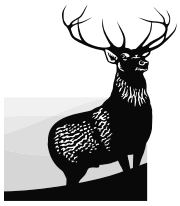
Newly eligible employees may choose to purchase coverage for your spouse of up to $50,000 guaranteed coverage without completing an Evidence of Insurability form. If you apply for coverage greater than $50,000 and up to $500,000 for your spouse, an Evidence of Insurability form must be completed and 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. **During the 2020-2021 Open Enrollment, Ongoing employees** may choose up to $50,000 for supplemental spouse coverage (without completing an Evidence of Insurability). To view new rates please visit **mpsaz.org/benefits**.

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.

ACCIDENT INSURANCE

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



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Highlights of the Accident Plan

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

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

Rates Per Pay Period

	Employee Contribution (Less than 12-month contract - 20 pay periods)		Employee Contribution (12-month contract - 24 pay periods)	
COVERAGE TIER	**LOW**	**HIGH**	**LOW**	**HIGH**
Employee Only	$2.52	$4.48	$2.10	$3.73
Employee & Spouse	$4.02	$7.13	$3.35	$5.94
Employee & Child(ren)	$4.32	$7.63	$3.60	$6.36
Employee & Family	$6.76	$11.95	$5.63	$9.96

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HOSPITAL INDEMNITY INSURANCE

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

Highlights of the Hospital Indemnity Plan

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

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

Rates Per Pay Period

	Employee Contribution (Less than 12-month contract - 20 pay periods)		Employee Contribution (12-month contract - 24 pay periods)	
Hospital Indemnity	**Low**	**High**	**Low**	**High**
Employee Only	$5.11	$9.05	$4.26	$7.54
Employee & Spouse	$10.58	$18.73	$8.82	$15.61
Employee & Child(ren)	$10.01	$17.60	$8.34	$14.67
Employee & Family	$16.21	$28.57	$13.51	$23.81

HOW TO SUMBIT A CLAIM

Retrieve the form online at **THEHARTFORD.COM/BENEFITS/MYCLAIM**. Submit the completed form and supporting documentation through the online portal at **THEHARTFORD.COM/BENEFITS/MYCLAIM**.

Or, you can mail or fax the form and documentation to:

The Hartford Supplemental Insurance Benefit Department
P.O. Box 99906
Grapevine, TX 76099

Fax Number: 1-469-417-1952

For assistance in completing this form, contact (866) 547-4205.

CRITICAL ILLNESS INSURANCE

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

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

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

Rates Per Pay Period

CRITICAL ILLNESS

Benefit Amount	Coverage Tier	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Employee Contribution (Less than 12-month contract - 20 pay periods)											
$10,000 (Low)	Employee Only	$1.85	$2.47	$3.49	$5.22	$8.22	$12.20	$17.28	$24.08	$33.29	$43.37
	Employee & Spouse	$3.05	$4.01	$5.56	$8.18	$12.79	$18.96	$26.81	$37.33	$51.44	$66.83
	Employee & Child(ren)	$3.13	$3.82	$4.86	$6.59	$9.54	$13.50	$18.54	$25.31	$34.45	$44.47
	Employee & Family	$4.60	$5.60	$7.19	$9.80	$14.38	$20.48	$28.28	$38.76	$52.80	$68.11
$20,000 (High)	Employee Only	$3.06	$4.30	$6.32	$9.74	$15.70	$23.65	$33.79	$47.41	$65.80	$85.96
	Employee & Spouse	$4.87	$6.73	$9.79	$14.99	$24.12	$36.41	$52.09	$73.14	$101.35	$132.12
	Employee & Child(ren)	$4.61	$5.98	$8.05	$11.48	$17.34	$25.19	$35.24	$48.74	$66.98	$87.01
	Employee & Family	$6.77	$8.78	$11.92	$17.10	$26.11	$38.26	$53.81	$74.71	$102.73	$133.33
Employee Contribution (12-month contract - 24 pay periods)											
$10,000 (Low)	Employee Only	$1.54	$2.06	$2.91	$4.35	$6.85	$10.17	$14.40	$20.07	$27.74	$36.14
	Employee & Spouse	$2.54	$3.34	$4.63	$6.82	$10.66	$15.80	$22.34	$31.11	$42.87	$55.69
	Employee & Child(ren)	$2.61	$3.18	$4.05	$5.49	$7.95	$11.25	$15.45	$21.09	$28.71	$37.06
	Employee & Family	$3.83	$4.67	$5.99	$8.17	$11.98	$17.07	$23.57	$32.30	$44.00	$56.76
$20,000 (High)	Employee Only	$2.55	$3.58	$5.27	$8.12	$13.08	$19.71	$28.16	$39.51	$54.83	$71.63
	Employee & Spouse	$4.06	$5.61	$8.16	$12.49	$20.10	$30.34	$43.41	$60.95	$84.46	$110.10
	Employee & Child(ren)	$3.84	$4.98	$6.71	$9.57	$14.45	$20.99	$29.37	$40.62	$55.82	$72.51
	Employee & Family	$5.64	$7.32	$9.93	$14.25	$21.76	$31.88	$44.84	$62.26	$85.61	$111.11

SHORT-TERM DISABILITY PLAN

You are eligible to enroll in Short-Term Disability (STD) benefits if you work 30 or more hours per week. STD benefits help replace lost income if you cannot work because you are totally disabled due to a non-work accident or illness, including pregnancy. Employees may 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. **There is a twelve-month pre-existing condition limitation that applies to new enrollments and increases in coverage. Pre-existing condition means a Sickness or Injury for which you received treatment within 12 months prior to your new enrollment and increase effective date.**

EMPLOYEE ASSISTANCE PROGRAM

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

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

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

EAP Preferred provides a range of legal and financial services to help with balancing life at Work and Home. Visit **eappreffered.com** for more information.

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 (aside from pension), Mesa is pleased to offer a 403(b) Savings Plan, 403(b) Roth, 457(b) Deferred Compensation Plan and 457(b) Roth Plan. Please visit the Benefits website for contact information for these plans.

VOLUNTARY BENEFITS INFORMATION

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

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

2020-2021 DEDUCTION SCHEDULE

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

PAY DATE		20 PAY PERIODS (Less than 12-month contract - 20 pay periods)	24 PAY PERIODS (12-month contract - 24 pay periods)
1	July 30, 2020		X
2	August 13, 2020		X
3	August 27, 2020		X
4	September 10, 2020	X	X
5	September 24, 2020	X	X
6	October 8, 2020	X	X
7	October 22, 2020	X	X
8	November 5, 2020	X	X
9	November 19, 2020	X	X
10	December 3, 2020	X	X
11	December 17, 2020	X	X
12	December 31, 2020	X	X

PAY DATE		20 PAY PERIODS (Less than 12-month contract - 20 pay periods)	24 PAY PERIODS (12-month contract - 24 pay periods)
13	January 14, 2021	X	X
14	January 28, 2021	X	X
15	February 11, 2021	X	X
16	February 25, 2021	X	X
17	March 11, 2021	X	X
18	March 25, 2021	X	X
19	April 8, 2021	X	X
20	April 22, 2021	X	X
21	May 6, 2021	X	X
22	May 20, 2021	X	X
23	June 3, 2021	X	X
24	June 17, 2021		X

FOR HELP OR INFORMATION

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

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

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QUICK REFERENCE CHART

INFORMATION NEEDED	WHOM TO CONTACT
Employee Assistance Program (EAP) • Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.	**EAP Preferred** Telephone: 602-264-4600 or 1-800-327-3517 Website: **www.eappreferred.com** Enter username: **MESAUSD** Enter password: **eappreferred**
Behavioral Health Program ***for all medical plan options*** • Mental Health and Substance Abuse Services and Providers • Precertification of Certain Behavioral Health Services • Behavioral Health Claims and Appeals	**CIGNA HealthCare (CIGNA)** Customer Service: 1-800-244-6224 (1-800-CIGNA24) Website: **www.mycigna.com** or **www.cignabehavioralhealth.com**
Healthy Pregnancy Healthy Babies Program • The CIGNA Healthy Pregnancies, Healthy Babies® program can help, providing education and support throughout your entire pregnancy – and after, if you complete the program, you could be eligible to receive an incentive of up to $250. • Healthy Pregnancy Healthy Babies is a collection of CIGNA benefits and an educational mailing available to you as part of your CIGNA HealthCare administered medical plan of benefits. The mailing includes a list of web resources, list of pregnancy related topics in the 24 hour Health Information Line audio library, a magazine, and brochures from the March of Dimes.	**Healthy Pregnancy Healthy Babies Program from CIGNA** Call 1-800-244-6224 Website: **www.mycigna.com**
Your Health First Program • Free health support services. CIGNA's Your Health First health experts trained as nurses, pharmacists, behavioral clinicians and health educators. They're available Monday through Saturday to speak with you one-on-one. They can help you find the best and most cost-effective health professionals and services in our area. You can call to ask questions about ways to improve your health and get additional information about medication and treatment options that your doctor may have mentioned. • Improve your lifestyle with effective stress, tobacco or weight management. • Better manage conditions such as depression, asthma, diabetes and more • Make the best decisions about treatment for common conditions like low back pain or heart disease. • Find ways to reduce health care costs by saving money on medications, treatments or other health related expenses.	**CIGNA Your Health First** The phone number is on the back of your ID card or call 1-800-244-6224.

QUICK REFERENCE CHART

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

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QUICK REFERENCE CHART

INFORMATION NEEDED	WHOM TO CONTACT
Life Insurance and Accidental Death and Dismemberment Insurance • The life insurance and accidental death and dismemberment insurance benefits are not fully described in this document. Contact the Employee Benefits Office for further information. • Submit death claims to the Employee Benefits Office at: 63 East Main Street, Suite 101; Mesa, AZ 85201. Phone: 480-472-7222 Fax: 480-472-0370.	**Sunlife** 1-800-247-6875 MPS Group Number: **213993** Website: **www.sunlife.com/us**
Flex Benefits Claims Administrator • Health FSA both General Purpose and Limited Purpose for HDHP participants • Dependent Care FSA	**CIGNA Healthcare** Customer Service: 1-800-244-6224 (1-800-CIGNA24) Website: **www.mycigna.com**
Short Term Disability	**Dearborn Group** 1-877-348-0487 MPS Group Number: **SA 03260**
Accident, Critical Illness, & Hospital Indemnity	**The Hartford** 1-866-547-4205 Policy Number: 681370 Website: **www.thehartford.com/benefits/myclaim**
Benefits Online Enrollment	**BenefitFocus** 1-877-336-8082
Help Desk • Password reset	**Mesa Public Schools Help Desk** 480-472-0044 Office Hours 6:30 a.m. - 5:00p.m. Monday through Friday
Retirement	**Arizona State Retirement System (ASRS)** 3300 N Central Ave Phoenix, AZ 85012 Member Services: 602-240-2000 Enrollment Code: **1YV00006** Website: **www.azasrs.gov**
Plan Administrator/Plan Sponsor	**Governing Board of the Mesa Unified School District #4** 63 East Main Street, Suite 101 Mesa, AZ 85201 Phone: 480-472-7222 Fax: 480-472-0370 Email: **benefits@mpsaz.org** Website: **www.mspaz.org/benefits**

IMPORTANT NOTICES

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

NOTICE OF MPS PRIVACY PRACTICE

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. HIPAA Privacy rules pertain to the following group health plan benefits sponsored by Mesa Public Schools:

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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

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

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

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

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

MEDICARE NOTICE OF CREDITABLE COVERAGE

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

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

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

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

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

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

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

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

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

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

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

TAX INFORMATION FOR FAILURE TO MAINTAIN MEDICAL PLAN COVERAGE

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

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

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

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

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

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

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

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

UNEMPLOYMENT INSURANCE

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

WORKERS' COMPENSATION

If you have a job-related illness or injury that requires medical care (beyond first aid) and/or requires you to take time off from work, you may file a claim for Workers' Compensation benefits. You are required to report your injury to your Supervisor and complete a Supervisors Report Of Injury (SROI). Arizona Workers' Compensation Law provides compensation benefits for employees who have an approved job-related illness or injury. Those benefits are determined by the Industrial Commission of Arizona. 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 (480) 472-0369.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

For periods of time in which you (or your covered dependents) have continuation coverage pursuant to both COBRA and USERRA, the law that provides the greater benefit will apply. The administrative policies and procedures described in the COBRA Election Notice also apply to USERRA coverage (unless compliance with the COBRA procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected, (both cannot be elected by the same person). For information about how to make a USERRA-only or COBRA-only election, consult the Plan Document for the Mesa Public Schools Plans, and contact the Mesa Public Schools Employee Benefits Office at 480-472-7222.

HEALTH CARE REFORM

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

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

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

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

PATIENT PROTECTION RIGHTS AFFORDABLE CARE ACT

If you are enrolled in any of the district's medical plans, you do not need prior authorization (pre-approval) from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care (OB/GYN) from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology (OB/GYN), contact CIGNA at 1-800-CIGNA24.

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

INFORMATION ON EMPLOYEE FRAUD AND ABUSE

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

- Adding a dependent to your coverage who you know is not eligible for coverage (for example an ex-spouse or over-age dependent child),
- Providing false or misleading eligibility, claims, or other affidavits/documentation to the Plan,
- 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 retroactively to the date you committed fraud or abuse, or
- Restitution for any claims/benefits that were inappropriately paid.

Serious criminal or civil consequences may result.

GENERAL NOTICE OF CONTINUATION OF COVERAGE (COBRA) RIGHTS

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

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

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

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

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

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

LEAVE/CONTINUATION OF COVERAGE WHILE ON LEAVE OF ABSENCE

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

FAMILY AND MEDICAL LEAVE ACT (FMLA) REMINDER

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

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

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

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

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

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

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

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

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

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

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

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

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

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

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

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

Employer Notice About The Health Insurance Marketplace

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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NOTICE REGARDING THE WELLNESS PROGRAM

The District's Wellness Incentive Program is a voluntary wellness program available to employees enrolled in the group health plan and is designed to **promote health or prevent disease**. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the Wellness Incentive Program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a certain activities such as free preventive exams or telephonic health coaching. You are not required to complete the HRA questionnaire, participate in the coaching or other medical examinations. However, individuals who choose to participate in the Wellness Program will receive an incentives in the form of points that can be used towards prizes such as gift cards. Although you are not required to complete the HRA or participate health screenings or work with a health coach, only employees who do so will receive the incentives.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes such as reducing their body weight. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Employee Benefits Department at (480) 472-7222.

The information from your HRA questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Wellness Program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

Our group health plan is required by law to maintain the privacy and security of your personally identifiable health information. Information collected from Wellness Program participants will only be received by your employer in aggregate form. Although the Wellness Program and the District may use aggregate information it collects to design a program based on identified health risks in the workplace, our group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by the group health plan to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Benefits Department at (480) 472-7222.

IMPORTANT INFORMATION ABOUT THE WELLNESS PROGRAM

Our Wellness Incentive Program is **voluntary** and is designed to **promote health or prevent disease**. The term Wellness Program includes both:

a. ways that we help individuals identify and reduce health risk factors, like elevated blood pressure or excess weight, along with

b. ways to help individuals with chronic conditions, like diabetes, take better care of their condition, for example by working with a coach to encourage you to take the medication the doctor prescribes for your chronic condition.

The Wellness Program also offers **incentives** for participation (such as for completing a Health Risk Appraisal questionnaire) and incentives if you positively change behavior (such as decreasing body weight). Only employees enrolled in one of our medical plan options at the District have the opportunity to qualify for Wellness Program incentives. Incentives are able to achieved at least **once a year**. **The time commitment required to achieve incentives in our Wellness Program is reasonable.**

The Wellness Program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan (including employee & employer contributions).

Reasonable Alternative Standard: If you think you might be unable to meet a standard for a certain reward under our Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the Wellness Program, then a reasonable alternative standard will be made available upon request. Contact [Human Resources] [the Wellness Coordinator] for information on the Wellness Program and for information on reasonable alternative standards and accommodations. We will work with you and, if you wish, your doctor, to find an alternative Wellness Program standard with the same reward that is right for you in light of your health status. If your personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: **http://myalhipp.com/**

Phone: 1-855-692-5447

ALASKA – 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**

ARKANSAS – Medicaid

Website: **http://myarhipp.com/**

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx**

Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – Medicaid

Website: **http://flmedicaidtplrecovery.com/hipp/**

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**

Phone: 678-564-1162 ext 2131

INDIANA – 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: **http://www.indianamedicaid.com**
Phone: 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: **http://www.kdheks.gov/hcf/default.htm**

Phone: 1-800-792-4884

KENTUCKY – Medicaid

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**

LOUISIANA – Medicaid

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

Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html**

Phone: 1-800-442-6003

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/**

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp** [Under ELIGIBILITY tab, see "what if I have other health insurance?"]

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**

Phone: 573-751-2005

MONTANA – Medicaid

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: **http://dhcfp.nv.gov**

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: **https://www.health.ny.gov/health_care/medicaid/**

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov/**

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/**

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: **http://www.insureoklahoma.org**

Phone: 1-888-365-3742

OREGON – Medicaid

Website: **http://healthcare.oregon.gov/Pages/index.aspx**
http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx**

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: **http://www.eohhs.ri.gov/**

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: **http://dss.sd.gov**

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: **http://gethipptexas.com/**

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**
Phone: 1-877-543-7669
VERMONT– Medicaid
Website: **http://www.greenmountaincare.org/**
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: **https://www.coverva.org/hipp/**
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: **http://mywvhipp.com/**
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf**
Phone: 1-800-362-3002
WYOMING – Medicaid
Website: **https://wyequalitycare.acs-inc.com/**
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

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