MENOMONEE FALLS SCHOOLS

Engage | Learn | Improve

2023 Benefits Guide

For new hires

Teacher, Custodian, Administrative Assistant, School Nutrition Manager, Recreation Supervisor, Superintendent, Administrator, Professional/Technical

Table of Contents

This brochure summarizes the benefit plans that are available to School District of Menomonee Falls eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Welcome!

At the School District of Menomonee Falls we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This guide will help you choose the benefits and level of coverage that is right for you.

Please take time to review your benefit choices and coverage details. Enrollment paperwork must be submitted to Stephanie Brandt in the HR Office via interoffice mail, regular mail, fax to 262-250-6494 or email to branste@sdmfschools.org no later than 30 days from your date of hire for any coverages you choose to enroll in.

You can also view more comprehensive benefit information by accessing your Employee Benefits Site.

Eligibility

Eligible Employees:
As a Teacher, Custodian, Administrative Assistant, School Nutrition Manager, Recreation Supervisor, Superintendent, Administrator or Professional Technical employee, you may enroll in the School District of Menomonee Falls Employee Benefits Program if you are a working at least 20 Hours per Week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your legal spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children and children obtained through court-appointed guardianship.

When Coverage Begins:

The District's benefits renew every January 1st. Newly hired employees and eligible dependents will be effective on the School District of Menomonee Falls' benefits programs on the first day of work when you enroll within 30 days of hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in you having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

Benefit Costs

The District pays the full cost of some of your benefits; you share the cost for some others. In addition, you pay the full cost for any voluntary benefits you elect.

Benefit	Who Pays	Tax Treatment
Medical Coverage	The District and You	Pretax
Dental Coverage	The District and You	Pretax
Vision Coverage	You	Pretax
Basic Life and Accidental Death and Dismemberment (AD&D) Insurance	The District	After-tax
Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance	You	After-tax
Long-Term Disability Coverage	The District	After-tax
Short-Term Disability Coverage	You	After-tax
Flexible Spending Accounts	You	Pretax
Employee Assistance Plan	The District	After-tax
403(b) Retirement Savings Plan	You	Pre or Post tax

PLEASE NOTE: Medical and Dental premiums are pro-rated to a maximum of 50% of the premium cost for part-time employees.

Medical Insurance

SDMF offers comprehensive Medical and Prescription Drug coverage to employees. The plan is a qualified high deductible health plan (HDHP) and employees who enroll may establish and fund a health savings account, if eligible.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details. The plan year deductible resets every January 1st. The network associated with the SDMF health plan is the **UHC Choice Plus Network.** When you see a UHC Choice Plus Network provider, clinic or hospital, you maximize your coverage under the health plan and pay less out-of-pocket.

	UMR - Medical HDHP	
Benefits Coverage	In-Network	Out-of-Network
Annual Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance	100%	50%
Maximum Out-of-Pocket*		
Individual	$4,000	$6,000
Family	$8,000 *(no one individual can exceed $6,550)	$12,000
Physician Office Visit		
Primary Care	100% After deductible	50% After Deductible
Chiropractic	100% After deductible	50% After Deductible
Specialty Care	100% After Deductible	50% After Deductible
Preventive Care		
Adult Well Check Exams	100%	50% After Deductible
Well-Child Care	100%	50% After Deductible
Diagnostic Services		
X-ray and Lab Tests	100% After Deductible	50% After Deductible
Urgent Care Facility	$75 copay per visit, after deductible	$75 copay per visit; 50% after deductible
Emergency Room Care	$250 Copay per visit, after deductible	$250 Copay per visit , after deductible
Inpatient Facility Charges	100% After Deductible	50% After Deductible
Outpatient Facility and Surgical Charges	100% After Deductible	50% After Deductible
Mental Health & Substance Abuse		
Inpatient	100% after deductible	50% after deductible
Outpatient	100% after deductible	50% after deductible

Retail Pharmacy (30 Day Supply)		
Generic	$10 copay after deductible	$10 copay after deductible
Brand Preferred	$25 copay after deductible	$25 copay after deductible
Brand Non-Preferred	$50 copay after deductible	$50 copay after deductible

Mail Order Pharmacy (90 Day Supply)		
Generic	$20 copay after deductible	$20 copay after deductible
Brand Preferred	$50 copay after deductible	$50 copay after deductible
Brand Non-Preferred	$100 copay after deductible	$100 copay after deductible

Pharmacy Benefits: Express Scripts

The District contracts with Express Scripts to manage our pharmacy benefits. When you enroll in the District's medical insurance coverage, you and enrolled dependents are automatically enrolled in the pharmacy coverage through Express Scripts.

Preventive Medications: The District offers an expanded list of preventive drugs covered under the high deductible health plan (HDHP) with ZERO cost share to members

Mail Order: Mail order is mandatory under the pharmacy benefits after two 30-day fills at a retail pharmacy. Members may choose to order through Express Scripts mail order service, or access the Walgreens Smart90 program.

Specialty Pharmacy: Certain Specialty medications must be obtained through Accredo, the specialty pharmacy vendor for Express Scripts.

2023 HDHP Health/Rx Premium Rates based on 8 hour work day					
Coverage Level	Total Premium	District Monthly Contribution	Employee Monthly Contribution	Premium per check (20)	Premium per check (24)
Single	$829.48	$721.65	$107.83	$64.70	$53.92
Family	$1,914.92	$1,665.98	$248.94	$149.36	$124.47

Note: For some employee groups, Cash In Lieu of electing the health plan coverage is offered in place of enrolling in SDMF's health/Rx plan. Enrolling in the Cash in Lieu payment requires an annual election, attestation, and proof of coverage. Please contact HR Benefits to see if this option is available to you.

FIND CARE & MEDICAL COSTS

Online tools that give you information about the cost or services based on location and medical provider. Log on to www.umr.com

LOWER YOUR PRESCRIPTION COSTS

Compare costs of generic and brand name medications to lower your out of pocket costs at www.express-scripts.com

Teladoc

Your Healthcare Just Got a Whole Lot Easier!

With Teladoc you can connect with a doctor who can diagnose, treat, and prescribe over the phone 24/7/365. Using Teladoc can SAVE YOU MONEY and no more time wasted in waiting rooms or trying to schedule an appointment.

Our doctors are licensed and can handle an array of common ailments including allergies, earache, sore throat, pink eye, strep throat, urinary tract infection, and many more! Teladoc also provides services for behavioral health and dermatology. Teladoc is great for families because your spouse and dependents can use it too. There is no limit on the number of times called or the duration of each call. It saves you time and money too!

- Physician visits are $49 or less
- Dermatology Visits are $85 or less
- Behavioral health is $90 for visits with a psychologist, licensed social work, counselor or therapist
- Psychiatrist visits are $220 for the initial session and $200 for ongoing visits

Sign up before you need services at www.teladoc.com

- 24x7 Unlimited doctor access
- FREE to use
- Access by app, online or telephone
- Spouse and dependent use
- Price and save prescriptions

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Real Appeal

Lose weight and get help to keep it off!
Feel Better, look better, be more active and improve your health!

- Weight loss program available to employees and spouses enrolled on the health plan at no cost to you
- Coaching
  - One-on-one with a weight loss expert for those who qualify
  - Weekly group coaching and live online discussion for all participants
- Personalized Support

  -Tools to help support success based on individual needs

  -Nutrition guides, meal plans, recipes, shopping lists video workouts fitness guides, online and mobile tracking tools to monitor nutrition and exercise
- Get started today at enroll.realappeal.com

real appeal

Dental Insurance

The District offers a comprehensive dental plan through Delta Dental. You may use any dentist for your dental services; however, using a PPO Provider will reduce your out-of-pocket costs.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Delta Dental of Wisconsin Inc.		
Benefits Coverage	PPO	Premeir/Out of Network
Annual Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum		
Per Person / Family	$2,000	$2,000
Diagnotic & Preventive: Exams, cleanings, floried treatments, x-rays, sealants	100%	100%
Basic Restorative Services: Fillings, endodontics, periodontics, extractions	80%	80%
Major Restorative Services: Crowns, inlays, onlays, bridges and dentures	80%	80%
Orthodontia (Adult coverage included)		
Benefit Percentage	50%	50%
Lifetime Maximum	$1,500	$1,500
Enhanced Benefits		
Evidence-Based Integrated Care (EBICP)		
EBICP provides benefits for additional teeth cleanings for persons with certain medical conditions that have oral health complications. Conditions include Diabetes, Pregnancy, Cancer, Periodontal disease, some specific heart conditions, Kidney failure or dialysis or a condition causing a suppressed immune system. EBPIC requires self-enrollment by calling Delta Dental at 800-236-3712. No medical claims need to be submitted or filed.		

Dental Premiums & Rates based on 8 hour work day					
Coverage Level	Total Premium	District Monthly Contribution	Employee Monthly Contribution	Premium per check (20)	Premium per check (24)
Single	$49.66	$43.20	$6.46	$3.87	$3.23
Family	$133.74	$116.35	$17.39	$10.43	$8.70

Vision Insurance

Your vision plan is offered through **EyeMed Vision Care** and is available on a voluntary basis to all eligible employees.

This is a comprehensive plan for all vision services. It provides coverage for routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses if you need them. You can see in- or out-of-network providers, however, keep in mind that you always save more money if you stay in-network. The name of the network is **EyeMed**, with over 2,000 providers in Wisconsin (100,000 nationally), including independent providers as well as several top retail providers.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Delta Eyemed Vision		
Benefit	In-Network	Non-Network Reimbursement
Comprehensive Spectacle Exam	You pay a $10 copay	$35
Retinal Imaging	Member pays up to $39	None
Contact lens fit and follow-up	$0	$40
Premium Contact Lens fit and follow-up	10% discount off retail, plus $40 allowance	$40
Frequency • Exam • Lenses • Frames	 Every 12 months Every 12 months Every 24 months	 Every 12 months Every 12 months Every 24 months
Frames	$150 allowance, then 20% off the balance	$75
Standard Lenses • Single vision lenses • Bifocal lenses • Trifocal • Standard Progressive	 You pay a $10 copay You pay a $10 Copay You pay a $10 Copay You pay a $75 Copay	 Up to $25 Up to $40 Up to $55 None
Lens Options		
UV Coating, Tint (solid & gradient), or standard scratch resistance	You pay a $15 Copay	None
Standard Polycarbonate	You pay a $40 Copay	None
Standard Anti-Reflective Coating	You pay a $45 Copay	None
Medically necessary contact lenses	Paid in Full	$200
Elective contact lenses-Conventional	$150 allowance, then 15% off balance	$120
Elective contact lenses-Disposable	$150 allowance	$120
Laser Vision Correction-Lasik or PRK	15% off retail price or 5% off promotional price	None

Vision Premiums & Rates					
Coverage Level	Total Premium	District Monthly Contribution	Employee Monthly Contribution	Premium per check (20)	Premium per check (24)
Single	$6.47	n/a	$6.47	$3.88	$3.24
Family	$16.07	n/a	$16.07	$9.64	$8.04

Health Savings Accounts

The SDMF medical plan is a Qualified High Deductible plan (QHDHP), allowing you to establish a health savings account. Health savings accounts are offered through the bank of your choice.

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a special account that enables you to pay for qualified medical, dental and vision expenses on a tax-free basis. You can also use this account to save for retirement as there is no "use it or lose it" rule.

You can use the money in your HSA to pay for eligible out-of-pocket health care expenses incurred by you, your spouse, and dependent children (that you claim on your tax return). However, your dependents do not need to be covered under the SDMF health plan to be eligible for reimbursement from your HSA.

You can also use money in your HSA to pay for out-of-pocket costs on prescriptions and over-the-counter (OTC) medications.

- CLICK HERE to read IRS Publication 969 regarding allowed over-the-counter medications and medical supplies
- CLICK HERE for the full IRS Publication 502 outlining qualified medical expenses

Special Note:

Be sure to keep your receipts for any funds used from your HSA. If audited by the IRS, you will need to prove the withdrawals were for qualified medical expenses. Any funds withdrawn for non-qualified expenses will be subject to income taxes and an additional penalty of over 20%.

There are many advantages of an HSA Account:

- Ownership – YOU own the account and the funds in your HSA
- Monies deposited are tax-free and there is NO "use it or lose it" provision
- Accounts are completely portable – you take the funds with you when you leave or retire
- You are allowed to change the amount you contribute at any time throughout the year
- You can choose to invest your savings in an investment account to maximize your funds for retirement if your bank allows this option

How much Can I Contribute?

The IRS sets and publishes the maximum contribution allowed in one calendar year:

2023 Maximum Allowed Contribution	
Single Coverage	$3,850
Family Coverage	$7,750
Catch-up Contribution: Those 55 years and older and not enrolled in Medicare can contribute an additional $1,000 "catch-up" each year	

Opening Your HSA:

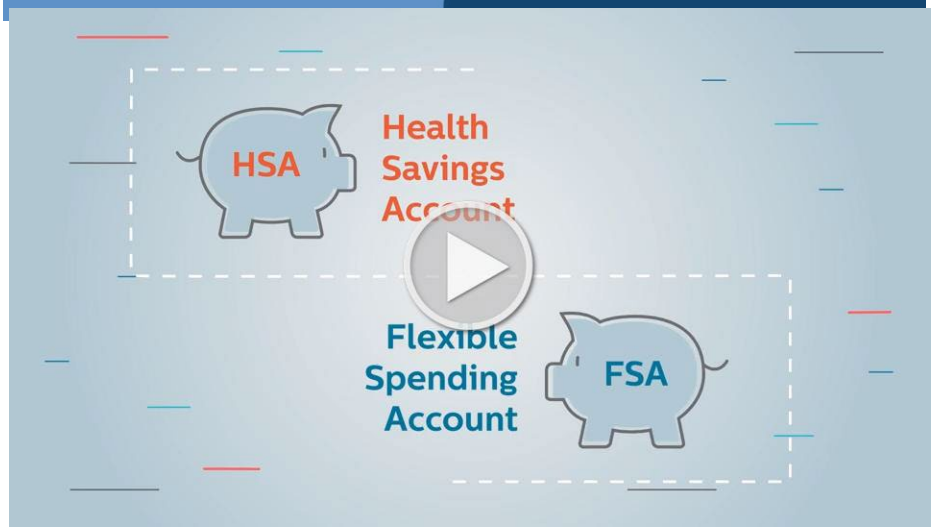
Employees who enroll in the health plan with the District are eligible to establish a health savings account. The District does not partner with a specific vendor and you may choose to establish your HSA with a financial institution of your choice. Payroll just asks that you submit a letter or statement from the financial institution confirming your account information and verifying that the account is a qualified Health Savings Account.

Our health plan offers an option through Optum Bank. If you would like to establish an HSA you may contact them directly at 866-234-8913, or www.optumbank.com.

There are many other financial institutions who offer HSA's as well and checking with your current bank may be a good option. In establishing a HSA, remember to review monthly maintenance fees, minimum balance requirements and investment options.

You may not establish and fund a HSA if any of the below apply:

- You are enrolled on another health plan that is NOT a qualified high deductible health plan
- You are covered under a FSA or HRA under another employer's health plan
- You are enrolled in Medicare or Tricare
- You are being claimed as a dependent on someone else's tax return (excluding spouses)



Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with School District of Menomonee Falls allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to the account(s) during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

If you have an HSA, the FSA can only be used for dental and vision expenses.

Account Options

- Health Care Spending Account (Section 125)*
- Limited Purpose Health Care Spending Account (Section 125)*
- Dependent or "Day Care" Spending Account (Section 129)

Important rules to keep in mind:

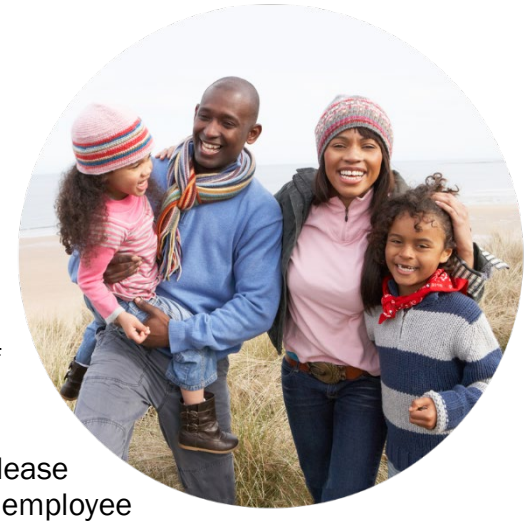
- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds exceeding the allowable rollover amount.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- Each component of the flexible benefit plan requires a separate election. You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds exceeding the allowable rollover amount by the end of the plan year will be forfeited. Re-enrollment is required each year.

Maximum Annual Election*		Allowable Rollover Amount Allowable
Health Care FSA	$2,850	Up to $570
Limited Purpose FSA	$2,850	Up to $570
Dependent Care FSA	$5,000	$0

Health care and Limited Purpose FSA contributions maximums are pro-rated based on the time you will be participating in the plan. I.e., if your effective is July 1st, you would be covered for ½ of the plan year and could contribute ½ of the maximum or $1,425

Life and Disability Benefits



Life and Accidental Death & Dismemberment Insurance:

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) Insurance is designed to provide a benefit in the event of death by accidental means or dismemberment, which includes loss of the use of certain body parts.

The District provides Basic Life and AD&D Insurance at no cost to you. Please refer to the Employee Benefits Site for the coverage applicable to your employee classification.

Please note that for employer paid policies exceeding $50,000, the IRS requires the cost of coverage to be included as income and taxed accordingly.

Supplemental Life Option:

Employees may purchase additional life insurance coverage for themselves, spouse and dependent children.

Employees who enrolled upon initial eligibility were guaranteed coverage per the table below. **Late enrollees would be subject to medical underwriting and carrier approval.**

Coverage	Guarantee Issue Amount	Maximum Amount
Employee	$125,000	$200,000
Spouse	$25,000	$50,000
Child	$10,000	$10,000

Rates are age banded for Employee and Spouse

Age Bands	Rate per $1000 of Coverage
Through Age 29	$0.040
30-34	$0.050
35-39	$0.070
40-44	$0.090
45-49	$0.150
50-54	$0.230
55-59	$0.390
60-64	$0.520

District Provided Long-Term Disability (LTD):

LTD covers 66.67% of your gross monthly earnings, up to a monthly maximum benefit of $10,556. Benefits begin after 60 calendar days of disability or illness and continue out to earlier of recovery or the age reduction scheduled as outlined in the certificate of coverage.

Voluntary Short-Term Disability (STD):

Employees may elect to enroll in short-term disability coverage by paying 100% of the cost. STD covers 66.67% of your weekly pre-disability earnings, to a maximum of $1,500 per week. Benefits begin on the 1st day for an accident and the 7th day for an illness and continue to the earlier of recovery or 60 days.

Short-term disability benefits are payable in conjunction with sick leave.

Employees who enroll upon initial eligibility are guaranteed a $301 weekly benefit amount. **If you do not elect coverage at the time of hire, you are considered a late enrollee and will be subject to underwriting and carrier approval.**

Salary range	Weekly Benefits	Monthly Premium Rate
$11,465 - $13,648	$147.00	$6.63
$13,649 - $17,470	$175.00	$7.74
$17,471 - $21,291	$224.00	$9.93
$21,292 – $23,475	$273.00	$12.15
$23,476 – $27,843	$301.00	$13.26
$27,844 - $32,757	$357.00	$15.83
$32,758 - $36,033	$420.00	$18.42
$36,034 - $39,309	$462.00	$20.26
$39,310 - $45,236	$504.00	$22.10
$45,237 - $52,022	$580.00	$25.39
$52,023 - $59,822	$667.00	$29.19
$59,823 - $68,791	$767.00	$33.57
$68,792 - $79,087	$882.00	$38.61
$79,088 - $90,942	$1,014.00	$44.40
$90,943 - $104,591	$1,166.00	$51.07
$104,592 - $116,993	$1,341.00	$58.73
$116,994+	$1,500.00	$67.54

Employee Pension

Wisconsin Retirement System (WRS)

Participation is required for any employees who are expected to work at least 880 hours within a rolling 12 month period and all eligible employees will be automatically enrolled in the Wisconsin Retirement System (WRS). If an employee becomes newly eligible during employment the employee will be notified by the payroll office and enrolled in the pension. Effective 1/1/23, the employee contribution requirement will be 6.80% of gross earnings per check, and the District matches it 6.80%.

The pension is managed by the State of Wisconsin, not by the District. Employees may contact the Pension directly at (608) 266-3285. Or you may visit the site online at etf.wi.gov.

Retirement Options

Annual Notice - 403(b) / 457 Retirement Savings Plans

The District offers voluntary retirement savings plans to help employees save for a secure retirement. All District employees are eligible to participate by making convenient payroll deducted contributions into a 403(b) or 457. Employees may enroll in the program at any time by contacting an approved provider; a representative will meet with you to complete the required paperwork for the enrollment. The District partners with the following three approved vendors:

Vendor	Contact Name	Contact Phone
Retirement Plan Advisors (formerly Security Benefit)	Angel Tullar	(866) 669-9500
WEA Trust Member Benefits	Dave Stelmaszewski	(800) 279-4030, Ext 3366
Wisconsin Deferred Compensation	Ryan Collier	(877) 457-9327

	Traditional 403(b)	Roth 403(b)	457 Deferred Comp	Roth 457
Contributions	Pre-Tax	After-Tax	Pre-Tax	After-Tax
Growth	Tax-Deferred	Tax-Free	Tax-Deferred	Tax-Free
Distributions	• Taxable • Available at age 59 ½ or separation of service • Withdrawals prior to age 59½ may be subject to 10% federal penalty unless separation of service occurred after age 55	• Tax-free at age 59½ and at least 5 tax years from date of first Roth 403(b) contribution • Withdrawals prior to age 59½ may be subject to 10% federal penalty	• Available at separation of service • Taxable • No age requirement. • No 10% federal penalty on early withdrawals	• Available at separation of service • Tax-free at age 59½ and at least 5 tax years from date of first Roth 457 contribution • No 10% federal penalty on early withdrawals (earnings may be taxable)
Annual Maximum Contributions (2023)	• $22,500 basic • $7,500 extra if over 50 years of age	• $22,500 basic • $7,500 extra if over 50 years of age	• $22,500 basic • $7,500 extra if over 50 years of age	• $22,500 basic • $7,500 extra if over 50 years of age
Loans	No	No	No	No
Hardships	Yes	Yes	Yes	Yes
Benefits	• Reduces taxable income • Provides tax-deferred income in retirement • Can combine 403(b) Roth, 403(b), 457, and 457 Roth plan contributions	• Tax-free growth • Provides tax-free income in retirement • Can combine 403(b) Roth, 403(b), 457, and 457 Roth plan contributions	• Reduces taxable income • Provides income for employees retiring before age 59 ½ • Can combine 403(b) Roth, 403(b), 457, and 457 Roth plan contributions	• Tax-free growth • Provides tax-free income in retirement • Can combine 403(b) Roth, 403(b), 457, and 457 Roth plan contributions

Employee Assistance Program

The District provides an Employee Assistance Program (EAP) to all eligible employees – at no cost. The EAP is designed to provide prompt, confidential help with a range of personal and family issues that may affect all of us from time to time.

OPTUM®
Live and Work Well

- Financial
- Stress
- Parenting
- Legal Counseling
- Family Issues

Contact your EAP at **(855) 205-9185** Or log on to **liveandworkwell.com** Access code: **Menomonee**

Mobile App

Our benefits app is MyBenefits2GO thru USI. It gives you on-the-go access to the School District of Menomonee Fall's benefit and insurance policy details, contact information and more!

HIGHLIGHTS OF THE MyBenefits2GO APP

- Stay Organized – Access all your plan information and cards in one place
- Stay Up To Date – Receive the most updated plan information automatically
- Lighten Up Your Wallet – Store your cards in the app
- Get In Touch – Convenient contact information

FIND IT IN THE APP STORE

Search for 'MyBenefits2GO' and download our free app. After scrolling through the intro pages
Enter this code when prompted: **P77521**

USI Benefit Resource Center (BRC)

The Benefit Resource Center ("BRC") is Here to Help!

It doesn't matter if you're a new hire or celebrating your 15th year, benefits and claims can be tricky to navigate. Our Benefits Specialists can help you translate confusing jargon and answer questions about which benefits your employer offers.
Plus, they can work directly with you and the insurance carriers to resolve issues related to claims and denials of service - and more!

Benefit Resource Center
BRCMT@usi.com | Toll Free: 855-874-0742
Monday through Friday 8:00am to 5:00pm
Monday through Friday 8:00 am to 5:00 pm CST

Contact Information

Carrier Customer Service

Additional information regarding benefit plans can be found on the District's Employee Benefits Site – CLICK HERE. Please contact Human Resources to complete any changes to your benefits that are not related to your initial enrollment.

	CARRIER	PHONE NUMBER	WEBSITE
Medical	UMR (TPA)	800-826-9781	www.umr.com
Prescription Drug	Express Scripts	800-837-6201	https://www.express-scripts.com/
Dental	Delta	800-236-3712	www.deltadentalwi.com
Vision	Delta/Eye Med	866-723-0514	https://www.deltadentalwi.com/s/find-a-deltavision-provider-near-you
Flexible Spending Accounts	Diversified Benefit Services, Inc.	800-234-1229	www.dbsbenefits.com
Life & AD&D Coverage	National Insurance Services	800-627-3660	
Short & Long-Term Disability Insurance	National Insurance Services	800-627-3660	
Employee Assistance Program	Optum EAP	855-205-9185	www.liveandworkwell.com
Wisconsin Retirement System	WRS/ETF	877-533-5020	http://etf.wi.gov
Benefit Resource Center	USI	855-874-0742	BRCMT@usi.com
SDMF HR Department	Stephanie Brandt	262-255-8396	branste@sdmfschools.org
SDMF Payroll Department	Corrine Wolff	262-255-8371	wolfcor@sdmfschools.org

When Does Coverage End?

For 10 month employees who resign/retire during the school year and all 12 month employees: Health, Dental, Vision, and Flexible Spending Account (FSA) coverage for the employees and all dependents ends on the last day of the month in which the employee resigns/retires. For 10-month employees who are completing the current school and resigning/retiring for the following school year, coverage ends on August 31st. For any employee on an unpaid leave of absence coverage will end if the required monthly premium contributions are not paid.

Coverage for dependents ends as follows:

- Spouse - coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.
- Dependent Child - End of the month in which adult child attains age 26. Coverage may continue beyond age 26 if, prior to attaining age 26, the child is mentally or physically disabled and chiefly dependent upon the subscriber for support and maintenance. Proof of such incapacity and dependency must be furnished by the subscriber to the district within 30 calendar days of the child's attainment of age 26.
- Loss of legal status - coverage ends at the end of the month in which the child no longer meets the definition of stepchild or legal ward. For example, a stepchild's parent is no longer legally married to the subscriber; legal ward's coverage ends at age 18.
- Emancipation - coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age 19.

Life and Disability Benefits: Group life insurance, long term disability coverage, and the voluntary benefits of short-term disability, supplemental life insurance, spousal life or child life insurance coverages end on your last day of employment or the last day of eligibility if you become ineligible for the benefit.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (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 and coinsurance applicable to other medical and surgical benefits provided under this plan.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

CONTACT INFORMATION

To request special enrollment or obtain more information, contact:

Stephanie Brandt, Human Resources Benefit Manager
W156 N8480 Pilgrim Road
Menomonee Falls, WI 53051
262-255-8396
Branste@sdmgschools.org

The School District of Menomonee Fall Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of the School District of Menomonee Falls Health Plan Health Information Privacy Practices (the "Notice") is January 1, 2023.

The School District of Menomonee Falls Health Plan (the "Plan") provides health benefits to eligible employees of the **School District of Menomonee Falls** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

> **Example:** The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company

must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

> **Example:** If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.
>
> **Example:** The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

> **Example:** The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.
>
> **Example:** The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

> **Example:** If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.
>
> **Example:** If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination

- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated Stephanie Brandt, Human Resource Benefits Manager, as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: W156 N8480 Pilgrim Road, Menomonee Falls, WI 53051, Phone: 262-255-8396.

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 July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

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.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact one of the SASD Payroll & Benefits Specialists, Support Staff/Admin Group - Pam Block (920-459-3528) or Professional /Teacher Group - Robin Couch (920-459-3527).

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name School District of Menomonee Falls	4. Employer Identification Number (EIN) 39-6003374	
5. Employer address W156 N8480 Pilgrim Road	6. Employer phone number	
7. City Menomonee Falls	8. State WI	9. ZIP code 53051
10. Who can we contact about employee health coverage at this job? Stephanie Brandt, Human Resources Benefits Manager		
11. Phone number (if different from above) 262-255-8396	12. Email address branste@sdmfschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Eligible employees are employees who are reasonably expected to work 20 hours a week or more based upon a determination made upon hire or change to a new position.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Eligible dependents are a lawful spouse of the covered employee and qualified dependent children as defined by the plan.

  - ☐ We do not offer coverage.

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)