ARLINGTON COMMUNITY SCHOOLS

Open Enrollment for Benefits
May 9 thru May 13, 2022

Open Enrollment is Here!

MAY 9 thru MAY 13

SLIGHT CHANGE (2%) to the medical premiums only! No increases to the Dental and Vision plans!

RATES FOR 22-23 SCHOOL YEAR

Medical Rates for MedBen Copay plan
(2% increase from previous year)

Employee Only (EO)	$92.95
Employee + 1 (EE+1)	$274.42
Family (Fam)	$382.82

Dental Rates for Delta Dental
(No Changes)

DPPO $2000 plan

Employee Only (EO)	$25.41
Employee + 1 (EE+1)	$53.35
Family (Fam)	$76.22

DPPO $1500 plan

Employee Only (EO)	$17.61
Employee + 1 (EE+1)	$36.96
Family (Fam)	$52.82

Vision Rates for Davis Vision
(No Changes)

Employee Only (EO)	$4.08
Employee + 1 (EE+1)	$7.80
Family (Fam)	$12.67

The first deduction with new premiums and changes made during Open Enrollment will be reflected on the 08/31/ 2022 paycheck.

TABLE OF CONTENTS:

This brochure provides a high level of benefit information. More detailed information can be found on the ACS **Employee Benefits webpage.**

The COPAY Plan	
Descriptions	**Plan Benefits**
*****WELLNESS (Routine Care)**	
Physical Exams (per ACA)	100%
Well Child Care (Including Immunizations)	
Mammogram (Test and Reading, including 3D and diagnostic mammograms)	
Pap Smears (Test and Reading)	
Prostate Blood Test/Colonoscopy (Test and Reading)	
Fecal Occult Screening (Test and Reading)	
MAJOR MEDICAL	
Deductible	N/A
Plan Payment (Coinsurance)	100%
Out-of-Pocket Max. (medical copays only)	$2,000/Indv. $3,750/Indv. + 1 $5,500/Fam.
**Out-of-Pocket Max. (Including medical and prescription copays per ACA)	$8,550 (Single)/$17,100 (Non-Single) *(Out of Pocket accumulators for prescription benefits are based on the member's actual cost)*
Lifetime Maximum per Family Member	Unlimited
*****Out of Pocket expenses accumulate on a calendar year basis.***	
***HOSPITAL BENEFITS**	
In-Patient	$500 copay per admission
Out-Patient	$250 copay per visit
Emergency Room	$250 copay per visit
Emergency Room copay waived if admitted due to Medical Emergency	
Maternity	100% after $500 copay *(does not include services performed in the physician's office)*
SURGICAL / PHYSICIAN BENEFITS	
In-Patient/Out-Patient	100%
PHYSICIAN OFFICE VISIT	
Primary Care	100% after $30 copay
CARE4US Onsite Clinics	100%, $0 copay (Prescriptions dispensed at time of service also have a $0 copay)
Specialist	100% after $45 copay
***DIAGNOSTIC SERVICES**	
Routine X-Ray & LAB Services (outpatient)	100%
*CAT Scan	100% after $150 copay
*MRI/MRA/PET Scans	100% after $250 copay
Diagnostic Imaging Facility, 6401 Poplar Ave, Ste 100, Memphis, TN · (901) 387-2340	$0 copay
PRESCRIPTIONS BENEFITS FILLED AT PHARMACIES	
Tier 1 -Generic	$10
Tier 2 - Preferred	20% up to $200
Tier 3 - Non-Preferred	20% + $50 up to $200

Discretionary/Elective Drugs	100% of discounted claim charge
Mail Order (90 day supply)	3 times retail pharmacy
Descriptions	**Plan Benefits**
The copays and out of pocket costs, listed above are based on a 30-day supply. Prescriptions filled for 60 days are doubled; 90 days are tripled.	
MENTAL/NERVOUS & SUBSTANCE ABUSE	
In-Patient	$500 per admission
Physician's Office Visit	100% after $30 copay
Intensive Outpatient Therapy	100% after $30 copay
***ADDITIONAL MEDICAL BENEFITS**	
Therapies (cognitive therapy, physical therapy, occupational therapy, speech therapy, pulmonary therapy)	100% after $30 copay (60 visits maximum)
Diabetic self-management and Cardiac rehab	100% after $45 copay each visit (60 visits maximum)
Chiropractic	100% after $45 copay (60 visits maximum)
Home Health Care	100% (60 visits maximum)(precertification required)
Extended Care Facility	$100 copay (60 visits maximum)
Hospice	100% (precertification required)
Urgent Care	100% after $50 copay
Ambulance Services	100% after $50 copay
Medical Supplies & DME	100% after $50 copay per device - (rental or purchase)
Chemotherapy Treatment	100% after $50 copay
Chemotherapy and Radiation Treatment at Baptist Facilities	$0 copay

**The Plan requires precertification by the Utilization Review Service prior to the commencement of the following services: all in-patient surgeries and procedures, any non-office based out-patient procedures, the purchase of durable medical equipment exceeding $1500, home health services, MRI, CAT and PET scans, just to name a few. Precertification confirms "Medical Necessity" ; therefore, services found not medically necessary, will not be approved for payment and are not be covered under the Plan. It is the member's responsibility to make sure precertification is obtained. Please refer to Article VI in the Plan Docuiment for a complete list of services or supplies and an explanation of all precertification requirements. Precertification is not required for any imaging services performed at Diagnostic Imaging Facility and for outpatient services rendered at Baptist Health Service Group of Mid-South, Inc. or St. Francis/Tenet.*

Plan Document: The plan document is the governing document; therefore, any discrepancies which may be found in this summary are not binding. The Plan Document may be found by going to the Employee Benefits Webpage or by contacting the Benefits office for a copy.

*****Wellness:** For a detailed listing of preventive services, please refer to Section 3.1 under RECOMMENDED WELLNESS SERVICE in the plan document.

The **COPAY Plan** uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated. Please contact MedBen at (800) 686-8425 (M-F 7:00 am - 5:30 pm), if you receive a bill for an amount above what your explanation of benefits (EOB) from MedBen says you owe. You may also email medben@medben.com.

The Care4Us clinics (Bartlett and Collierville) are open to all insured employees and their covered dependents for acute and primary care services. There is no copay for services, and for prescriptions received at the clinic. Please call (901) 979-3151 or login to www.mypremisehealth.com to schedule your visit today.

More information regarding the Care4Us Onsite Clinics is in the Brochure

Balance Billing

Q. What is a "Balance Bill"?

A. It is a bill from a provider for any amount over what MedBen has paid. (It does not include if the member is being billed for his or her co-pay)

Q. If I receive a Balance Bill or a phone call about charges that have been disputed by my health coverage, what should I do?

A. You should call MedBen IMMEDIATELY at (800) 686-8425.

Q. What if I get a call from a facility regarding a Balance Bill?

A. If you have not already called MedBen, please do at (800) 686-8425.

Q. After I have returned my paperwork and Balance Bill from my facility to MedBen and I receive another call, what should I tell the caller?

A. Let them know you have appointed MedBen as your Authorized Representative under your Health Plan and give them the MedBen number to call: (800) 686-8425.

Q. Will you process the Balance Bill if the patient hasn't paid the portion they're responsible for (i.e., deductible and/or coinsurance)?

A. The Balance Bill cannot be handled by MedBen or HST unless the true patient responsibility (based on the MedBen EOB) is either paid off or put into a payment plan.

Taking advantage of discounts offered helps to avoid increased costs both for members and the plan. With your help, every dollar you save is a savings to the plan and potentially avoid premium increases!

With that in mind, ***DID YOU KNOW*** there are several services with zero copay and zero out of pocket?

BENEFITS WITH ZERO COPAY

BAPTIST Chemotherapy and/or Radiation services received at ***Baptist facilities.*** The best care at the lowest possible cost!

https://www.baptistcancercenter.com/
https://www.baptistcancercenter.com/locations/baptist-cancer-center-bartlett

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Do you need a Radiology test such as a CT, MRI, Ultrasound, X-Ray, or PET Scan? These tests are covered at 100% and $0 copay at Diagnostic Imaging ONLY

evocare Your Ally in Care Coordination

- Have your physician schedule your appointment at Diagnostic Imaging 6401 Poplar Ave. Ste. #100, Memphis, TN 38119. (901.387.2340)
- Present your MedBen insurance card, which indicates your eligibility with the EvoCare logo

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CareOUs Operated by Premise Health

"Onsite" site medical clinics at zero cost for employees and dependents covered under the medical plan.

- Office visits and prescriptions dispensed at the clinic
- Mail-Order for maintenance drugs normally dispensed at the clinic

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EVERY LITTLE BIT HELPS!

Savings on out of pocket expenses, may be found by using the following facilities and services:

- **BAPTIST hospital and providers:** www.baptistonline.org/find-a-doctor
- **ST. FRANCIS hospital and providers:** www.saintfrancishosp.com/location
- **BAPTIST Mail-Order Pharmacy**—Call Baptist 1-833-721-3900 or email mailorder@bmhcc.org
- **SPECIALTY Drugs—Call Baptist** at 1-844-605-5496 or email specialty@bmhcc.org
- **COSTCO Mail-Order Pharmacy**—pharmacy.costco.com, 1-800-607-6861
- **GENERIC drugs**—A generic drug is a medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality, and performance characteristics (FDA.gov)
- **DISCOUNT pharmacies**—such as Costco, Kroger, Target, Fred's, and Walmart
- **GOODRX app**—Using the GoodRX app, helps you locate the cheapest out of pocket cost for drugs you may be unable to purchase in generic. It also helps you find "coupons" for additional savings. www.goodrx.com

Delta Dental will continue to provide dental services in 2022. Finding a network dentist is easy. Simply visit www.DeltaDentalTN.com, or call Customer Service hotline at 800-223-3104.

	PLAN OPTION #1 DPPO $2000	PLAN OPTION #2 DPPO $1500
DIAGNOSTIC & PREVENTATIVE—such as cleanings, oral exams, x-rays, fluoride treatments	100%	100%
BASIC SERVICES—such as fillings, general anesthesia, simple extractions, injectable antibiotics, perio maintenance	80%	80%
MAJOR SERVICES—such as crowns, bridges, dentures	60%	50%
ORTHODONTIC SERVICES	50%	50%
CALENDAR YEAR MAXIMUMS (Per Person, excludes Orthodontics	$2000	$1500

Did you know the district provides 2 times your annual salary in Basic Life benefits at no cost to you?

Life and Disability Benefits

*Basic Life Benefits

- ⇒ 2 times annual contract salary
- ⇒ AD&D also 2 times annual salary
- ⇒ District Pays 100%
- ⇒ Maximum Benefit $300,000
- ⇒ Reduces 35% at age 65
- ⇒ Reduces 50% at age 70 or at retirement, whichever is first

*Optional Life Benefits

- ⇒ May add additional employee, spouse and child life
- ⇒ Includes AD&D

*Long-Term Disability

- ⇒ Pays 60% of your pre-disability earnings

*Any Optional Life Benefit and/or LTD added during Open Enrollment is subject to medical underwriting.

Davis Vision will continue to provide Vision services in 2022, and offers the following benefits:

- $10 copay for eye exam
- Lens replacement every year
- Contact lenses, in lieu of glasses, replaced ever year, $150 retail allowance toward purchase
- Frame replacement every other year
- Additional discounts on lens options and coatings

Login to your online benefits at www.davisvision.com or call **(800) 999-5431.**

This year there is no change in premium. Advertised rates have been locked in until 2024.

HOW TO ACCESS YOUR EMPLOYEE PORTAL

To review your check, you need to login to the Employee Portal.

- Go to www.acsk-12.org.
- Go to "Employees" on the top menu bar and select "Employee Portal".
- Log in with your user ID and your password. You can choose "forgot password" if you aren't sure of your password.
- Once logged in, go to "Payroll" and choose the 08/31/2022 check to review the deductions.
- Deductions that are "active" would show amounts in the "Voluntary Deductions" section.
- If you see that a correction needs to be made, please reach out to the benefits department as soon as possible to correct.

WHAT ELSE CAN I SEE ON THE EMPLOYEE PORTAL?

- ✓ Review your W-2
- ✓ Change direct deposit
- ✓ Change your W-4 withholdings
- ✓ Change your mailing address
- ✓ Documents/Links

REVIEW YOUR 08/31/2022 CHECK

Any changes made during Open Enrollment will become effective September 1. Payroll deductions for benefits will resume on 08/31/2022. It's is very important to review that first check to make sure you are being deducted for the benefits elected during Open Enrollment.

Please also retain your Benefit Statement emailed to you after making your benefit selections. This will help you to compare your deductions.

On your Benefit Statement, please review the following

- ✓ **Is the date of birth for all members correct?**
- ✓ **The Benefit Statement lists the benefits beside each member's name, so you know what they have. (Please review to make sure that information is correct).**
- ✓ **Is your mailing address correct?**
- ✓ **Is your Social Security Number and that of your dependents correct?**

HOW TO ENROLL IN BENEFITS

Per the Affordable Care Act (ACA), open enrollment is mandatory for EVERY full-time employee, even if you do not wish to elect coverage, and even if you do not wish to make any changes to your existing coverage. American Fidelity agents will meet with each employee individually to complete enrollment. The 2022/23 ACS Benefits Flyer will be sent to all employees via a Broadcast email from Dr. Allison Clark providing a link to the scheduler. You will use the link to schedule your benefits enrollment appointment with an American Fidelity representative. You will have the opportunity to make changes to all benefits, including the following:

- Health / Dental / Vision
- Optional Life benefits
- Flexible Spending / Dependent Childcare
- Cancer / Critical Illness / Short-Term Disability / Accident

All benefit changes, cancellations and/or enrollments become effective 09/01/2022.

Care4Us | Operated by Premise Health

Premise Health manages the CARE4US medical clinics for employees and their dependents who are covered under the medical plan. All services received at the clinic, including prescriptions are at no cost to the member. If the clinic is booked or if it's after hours, then you may be seen at Kroger's "The Little Clinic" and your copay will be waived. *(You must call Premise Health to receive a voucher number. Prescriptions written at The Little Clinic are subject to the medical plan co-pay)*

Register with Premise Health

Each family member enrolled in the ACS health plan must be registered separately. In order to register, please visit www.mypremisehealth.com .

1. Click SIGN UP NOW
2. Complete the sections with a red asterisks
3. Click on the CAPTCHA box
4. Click Submit

2 Convenient Locations

CARE4US in Bartlett
7665 US Hwy 70, Suite #101,
Bartlett, TN 38133

CARE4US in Collierville
777 W. Poplar Ave, Suite #104,
Collierville, TN 38017

Call the Premise Health Patient Support Center at

(901)979-3151

COMING SOON!

Care4Us Pharmacy

Your preferred choice for all medicine needs

- ⇒ **Low copays**
- ⇒ **Convenient and friendly service**
- ⇒ **Mail-Order**

Conveniently located next to the Care4US clinic in Bartlett.
More details to follow

To Schedule an appointment after hours at The Little Clinic

- ⇒ **MUST** call the Premise Health Patient Support Center at (901)979-3151.
- ⇒ If your Health Center is closed or you are unable to receive care at your center, ask the Premise Health Support Center Advocate for the Premise Health Referral Number to visit The Little Clinic nearest you.
- ⇒ Present your referral number to The Little Clinic upon arrival. Your Premise Health Referral Number will be effective for 24 hours. The Little Clinic will take care of the rest.

The Little Clinic
Convenient Neighborhood Medical Care

Call the Premise Health Patient Support Center at (901)979-3151

CONCERN EAP
Your Employee Assistance Program

CONCERN (EAP) Employee Assistance Program

Life situations can become very stressful… but we can help

When we begin to experience personal problems, reaching out to family, friends, or others can be very supportive and satisfying. However, if additional help is needed, your employer has made available to you and your immediate family a professional counseling service that can help you resolve these problems. The program is called CONCERN and it is your employee assistance program.

What Does Concern Cost?

The services of CONCERN are paid by the district. There is no cost to you or your dependents if services are used.

How does Concern Work?

If you need to talk over a problem with a CONCERN counselor, simply call for an appointment. During your first visit or two, the counselor will listen and try to gain a clear understanding of your problem, help you sort out options, and develop a problem-resolution plan with you. Help can usually be found through continued short-term counseling at CONCERN. If additional or specialized help is needed, your counselor will put you in touch with a qualified professional or a support group best suited to help. Your counselor will remain available to you until you feel the difficulties are under control.

How Confidential Is The Service?

Strict confidentiality is maintained by CONCERN. The employee or dependent calls to make his own appointment. No one will know of your participation unless you tell them or give your counselor permission to speak with someone. CONCERN complies with all state and federal laws regarding confidentiality.

CONCERN has multiple office locations as well as day and evening appointment times.

To make an appointment call

(901) 458-4000

FLEXIBLE SPENDING ACCOUNTS
(American Fidelity)

A Health FSA can save you money by allowing you to set aside part of your pay, on a pre-tax basis, to pay for eligible medical, dental and vision expenses such as co-payments, medical deductibles, prescriptions, and much more. Expenses incurred by you, your spouse, and other qualifying individuals are eligible. A flex debit card allows you to use Flex funds at the time of service, giving you direct access to your FSA funds and helping you avoid waiting on reimbursement checks!

What Else Should I Know?

◊ Funds are immediately available on September 1
◊ Save your receipts, you may be asked to "verify" your purchase
◊ There is no carry-over of unused funds to the next plan year. For that reason, please be ***CONSERVATIVE*** when selecting an annual benefit, so you don't lose unused funds.

The maximum amount you may set aside is ***$2,850*** per plan year.

Did you know that employees and/or their dependents do not have to be enrolled in the Medical benefits to take advantage of the benefits under the flexible spending plan?

OTHER AMERICAN FIDELITY BENEFITS

Dependent Day Care FSA

A Dependent Day Care FSA allows you to set aside pre-tax dollars to reimburse yourself for incurred eligible dependent care expenses. You may allocate up to $5,000 per plan year for reimbursement of dependent day care services ($2,500 if you are married and file a separate tax return).

Short-Term Disability

American Fidelity pays you 60% of your monthly salary if you had to be out of work for a covered accident, sickness and even maternity for the 6 or 8 weeks while under doctor's care. Please ask an American Fidelity Representative for details and exclusions

* Affordable Premiums
* Pays benefit directly to you

Cancer

American Fidelity's Cancer insurance can help offer financial protection so you can focus your attention on fighting cancer. These plans can help assist with out-of-pocket costs often associated with a cancer diagnosis.

* Receive a benefit for visiting your doctor annually for a cancer screening test (Mammogram, Pap, and PSA)
* You can take the benefit if your leave or retire

Critical Illness

American Fidelity's Critical Illness insurance can be the solution that helps you and your family focus on recovery from a critical illness such as a heart attack or stroke, and may help you with paying bills. In addition, it can assist with the expenses that may not be covered by standard medical insurance.

Accident

American Fidelity's Accident only insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. It is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

If you are interested in any of the benefits described above, your American Fidelity representative will be able to assist.

Also once enrolled, please visit www.americanfidelity.com to view benefits and download claim forms, or call (800) 662-1113

SUPPLEMENTAL RETIREMENT OPTIONS

401(k) and 403(b) refer to the Tax Code which governs defined contribution retirement plans. Employees participating in a 401(k) or 403(b) supplemental retirement option may defer a portion of their salary pre-tax. The 401(k) plan is offered by Empower and the 403(b) is offered by VALIC. For the most part the rules are the same, but we usually associate a 401(k) with private sector plans and a 403(b) with education or governmental plans. The contribution limits for both are the same.

Roth 403(b) or 401(k) also refers to the associated Tax Code which governs defined contribution retirement plans. A Roth is an after-tax supplemental retirement plan.

457 refers to the Tax Code which governs defined contribution retirement plans. Employees participating in a 457 supplemental retirement option may defer a portion of their salary pre-tax. In the "good ole days" this plan was referred to as a Deferred Compensation plan and was specifically designed with educators in mind. The rules around distributions are much more relaxed, taking into consideration that some educators can retire prior to age 60 and need access to funds much earlier.

What are the contribution limits? In 2022, the maximum contribution amount is $20,500. It may be indexed for inflation in $500 increments after 2022. If you turn age 50 or older in 2022, you may contribute an additional $6,500.

Can employees make Roth 401(k) or 403(b) contributions? In 2022, the maximum limit for elective deferrals, for both traditional pre-tax and Roth 401(k) and/or 403(b) contributions combined, is $20,500. Roth contributions are made with after-tax dollars, instead of the pre-tax dollars you contribute to a traditional 401(k) or 403(b). In other words, with the Roth option, you've already paid taxes on the money you contribute.

Can employees contribute to multiple plans? Yes, however; if an employee contributes to another plan, such as a 403(b) plan, the combined total of all contributions cannot exceed the maximum limit of $20,500 in 2022, or $26,500 if age 50 or older. Governmental 457(b) plans have separate deferral limits, so employees who contribute to a 457(b) plan may be able to contribute an additional $20,500 to that plan in 2022 (plus any applicable catch-up contributions). For more information about contribution limits for multiple plans, visit **www.irs.gov**.

Who may participate? Both full time and part time employees are eligible to participate.

Please contact VALIC or Empower directly if you are interested in participating.

EMPOWER – 1-800-922-7772 or www.retirereadyTN.com , Monday thru Friday, 8am to 5pm (CST)

VALIC – Bailey Rihner – 901-208-2714, Bailey.Rihner@aig.com

CONTACTS

MedBen ..... (800) 686-8425; Email: medben@medben.com
Medical and Pharmacy

DELTA DENTAL ..... (800) 223-3104 Dental

DavisVision ..... (800) 999-5431 Vision

CONCERN EAP EMPLOYEE ASSISTANCE PROGRAM .....(901) 458-4000 EAP

AMERICAN FIDELITY a different opinion .....(800) 465-2129 (FSA); (800) 662-1113 (Other products)
FSA Administration/Short-Term Disability/ Accident/Cancer/ Critical Illness.

TheStandard .....(800) 348-3226; Life and Long-Term Disability

CareOUs Operated by Premise Health .....(901) 979-3151

ARLINGTON COMMUNITY SCHOOLS Established 2014 ACS Employee Benefits Department.....(901) 389-2497, Ext. 2220 benefits@acsk-12.org

Did you know if your spouse is covered under the district's medical plan, a Spouse Affidavit is required each year to verify his or her eligibility?

Please complete the form on the next page, scan and email to benefits@acsk-12.org or stephanie.moore@acsk-12.org

Arlington Community Schools
12060 Arlington Trail
Arlington, TN 38002

Phone: (901) 389-2497
Fax: (901) 389-2499
E-mail:
benefits@acsk-12.org

ARLINGTON COMMUNITY SCHOOLS Established 2014

LIFESIGNS PHYSICAL EXAM CLINIC

Have you had your annual physical? LifeSigns can conduct a comprehensive physical. See below a list of a few of the tests you may receive at LifeSigns:

- Ultrasound of the thyroid
- Ultrasound of the carotid arteries
- Treadmill stress test
- Digital mammography
- omen s ellness
- Chest X-ray

Call at (901) 685-5520 or visit online at www.lifesigns.com

ARLINGTON COMMUNITY SCHOOLS

SPOUSE HEALTHCARE ELIGIBLITY AFFIDAVIT

Employee Name:	Last four of SSN(Employee):
Spouse Name:	Last four of SSN (Spouse):

Section A: Must complete to enroll your spouse in Group Health Plan Coverage.

☐ **1** Spouse is not employed or is Retired

☐ **2** Spouse is an employee of one of the Municipal School Districts or Cities listed below:
(Please check one)

- ☐ Arlington Community Schools
- ☐ Collierville Schools
- ☐ City of Bartlett
- ☐ City of Lakeland
- ☐ Bartlett City Schools
- ☐ Lakeland School System
- ☐ Town of Collierville

☐ **3** Spouse is employed or self-employed ***WITHOUT*** access to coverage from his/her employer (**MUST COMPLETE SECTION B**)

☐ **4** Spouse is employed ***WITH*** access to coverage from his/her employer but employer pays less than 50% of the cost (**MUST COMPLETE SECTION B**)

NOTE: ***If none of the above applies then he or she is not eligible for the Group Health Plan. (He or she is eligible for other benefits such as dental, vision, life.)***

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit my employer to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Group Health Plan coverage.

Employee Signature:	Date:
Spouse Signature:	Date:

Section B: Must be completed by spouse's employer. (or spouse if self-employed)

Is the person named above as Spouse *eligible* for coverage with your company?

☐ Yes ☐ No

If yes, does your employee's share, ***exceed 50%*** of the total cost of premiums for your cheapest individual coverage?

☐ Yes ☐ No

Employer Name:_____ **Employer Phone:**_____

Employer Address:_____

Authorized Employer Name:_____ **Title**_____

Authorized Employer Signature:_____ **Date:**_____

Please return the completed document to the ACS Employee Benefits office:
Email: benefits@acsk-12.org , stephanie.moore@acsk-12.org or Fax: (901) 389-2499
Questions? (901) 389-2497 Ext. 2220

LEGAL NOTICES

Arlington Community Schools (MSSC) EMPLOYEE BENEFIT PLAN Notice of 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.

This notice will become effective on _03-20-2022_____.

At*, MSSC* we respect your privacy and will protect your health information responsibly and professionally. This notice describes the privacy practices of the Medical, Dental, Vision and prescription drug programs (the "Health Plan") included in the MSSC Employee Benefit Plan. This notice does not apply to disability benefits, life insurance, or any non-health plans or benefits.

As you read this notice, you'll see the term "Protected Health Information" or PHI. Protected health information is health information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care) that is created or obtained by the Health Plan in connection with your eligibility for or receipt of benefits under the Health Plan.

Federal law requires that the Health Plan maintain the privacy of protected health information, give you this notice of the Health Plan's legal duties and privacy practices, and follow the terms of this notice as currently in effect.
These protections will remain in effect with regards to your protected health information held by the Health Plan during your lifetime, and for at least 50 years following your death.

MSSC contracts with claims administrators and other third parties to provide Health Plan services. For purposes of this notice, the "Health Plan" includes third parties when performing services for the Health Plan, including persons or entities creating, receiving, maintaining or transmitting your protected health information in connection with your health coverage (referred to in this notice as "business associates"). Protected health information may be shared among the components of the Health Plan and the third parties providing services for the components of the Health Plan in the course of payment, Health Plan operations, and treatment. The current claims administrators are listed under Contact Information, below. When their services involve the use of protected health information, the third parties and their subcontractors will be required to perform their duties in a manner consistent with this notice.

How the Health Plan Uses and Shares PHI for Payment, Health Plan Operations, and Treatment

Below are some examples of ways that the Health Plan may use or share information about you for treatment, payment, and Health Plan operations. For each category, a number of uses or disclosures will be listed, along with an example. However, not every use or disclosure in a category will be listed. The Health Plan may use or share your protected health information for:

- **Payment:** The Health Plan will use and disclose your protected health information to determine and pay for covered services. Payment activities include determining eligibility; conducting pre- certification, utilization, case management, and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints, and appeals. For example, the Health Plan may use your medical history and other health information to decide whether a particular treatment is medically necessary and what the payment should be. During that process, the Health Plan may disclose information to your provider. Any request for information or use of such information involving psychotherapy notes will only be done with your written authorization. The Health Plan will mail Explanation of Benefits forms and other information to the employee at the address it has on record for the employee.

- **Health Plan Operations:** The Health Plan will use and disclose your protected health information for Health Plan operations. Operational activities include quality assessment and improvement; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management, and care coordination. For example, the Health Plan may use protected health information to provide disease management programs for participants with specific conditions, such as diabetes, asthma, or heart failure. Other operational activities requiring use and disclosure of protected health information include administration of stop loss coverage, including underwriting of such coverage; legal, actuarial, and audit services; business planning and cost management; detection and investigation of fraud; administration of pharmaceutical programs and payments; and other general administrative activities, including data and information systems management and customer service. We will not use or disclose any genetic information involving you for underwriting purposes.

- **Treatment:** The Health Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Health Plan may disclose protected health information to doctors, dentists, pharmacies, hospitals, and other health care providers who take care of you. For example, doctors may request medical information from the Health Plan to supplement their own records. The Health Plan may also send certain information to doctors for patient safety or other treatment-related reasons.

The Health Plan may also disclose protected health information to providers or other health plans for the payment, treatment, and certain operational activities of the provider or other health plan.

How the Health Plan Uses and Shares PHI for Communications about Benefits

The Health Plan may use or disclose protected health information to send you treatment reminders for services such as mammograms or prostate cancer screenings. Also, the Health Plan may use or disclose your protected health information to give you information about alternative medical treatments and programs or health-related products and services that may be of interest to you. For example, the Health Plan might send you information about smoking cessation or weight-loss programs. Disclosures involving the sale of your health information to another entity for marketing purposes, or for any purpose not disclosed in this notice, will only be done with your written authorization.

Disclosures that the Health Plan May Make to Others Involved in Your Health Care

The Health Plan may disclose protected health information to a family member, a friend, or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls the Health Plan with prior knowledge of a claim, the Health Plan may confirm whether or not the claim has been received and paid. You may instruct the claims administrator to stop or limit this kind of disclosure. We will continue to permit such disclosure to these individuals following your death, unless doing so is inconsistent with any prior expressed preference made by you that is known to us.

Disclosures You May Authorize the Health Plan to Make

The Health Plan will not use or disclose your protected health information for any reason other than those listed in this notice unless you provide a written authorization.

You may give the Health Plan written authorization to use and/or disclose your protected health information to anyone for any purpose. If you give the Health Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure made pursuant to your authorization while it was in effect.

Disclosures that the Health Plan May Make to *MSSC*

To determine if and when you and your family members are covered by the Health Plan, the Health Plan will share enrollment information about you and your family members with ***MSSC***.

The Health Plan will periodically disclose protected health information to ***MSSC*** Human Resources Representatives so that the Human Resources Representatives can assist participants with benefits questions and oversee the administration of the Health Plan. Also, the Health Plan will periodically disclose protected health information to the Finance Department of ***MSSC*** so that the Finance Department can perform financial planning and projections and monitor the performance of third parties. In addition, the Finance Department is responsible for paying the claims covered by the Health Plan.
The Human Resources Representatives and the Finance Department will only use the protected health information for the purposes for which it was disclosed or as required by law.[1] Specifically, ***MSSC*** certifies that it will:

- Not use or disclose protected health information for employment-related actions and decisions or in connection with any non-health benefits or another employee benefit plan sponsored by ***MSSC***;
- Not use or further disclose protected health information other than as permitted or required by this notice or as required by law;
- Ensure that any business associates (including a subcontractor) to whom ***MSSC*** provides protected health information received from the Health Plan agree to the same restrictions and conditions that apply to ***MSSC*** with respect to such information. If any of our business associates fails to take adequate steps to safeguard and protect your health information, including controlling the activities of any of their subcontractors, and to perform the activities necessary to fulfill their responsibilities in regards to such information, including the corrective actions necessary due to a breach, we will terminate our relationship with such entities, if feasible;
- Provide training to our employees, including volunteers, trainees and others who are under are our direct control with access to protected health information maintained by the Health Plan on their responsibilities under the law, including the safeguarding and protection of the information. We will also establish and enforce disciplinary measures against such employees for violations of such responsibilities, and will require our business associates and their subcontractors to do the same;
- Report to the Health Plan's Privacy Officer any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which ***MSSC*** becomes aware;
- Provide notification to you within a reasonable time of our discovery of an impermissible use or disclosures of your protected health information (breach), unless we reasonably determine that there is a low probability that such information has been. Such notification will also be provided to the media or the U.S. Secretary of Health and Human Services if required by law. We will also provide you with notification of any such breaches committed by our business associates, unless we have delegated the responsibility for such notifications to the business associate who is responsible for the breach;
- Confirm that the Health Plan makes your protected health information available to you for access, amendment, and/or accounting, as described below;
- Make internal practices, books, and records relating to the use and disclosure of protected health information received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Health Plan with federal law;
- Return protected health information to the Health Plan (when feasible), destroy protected health information (when return is not feasible and retention is not required by law), or continue to maintain the privacy of all protected health information (when return is not feasible and retention is required by law);
- Use its best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested; and
- Ensure adequate separation between the employees who are Human Resources Representatives or in the Finance Department and all other employees of ***MSSC*** with access to Health Plan information so that protected health information received by these individuals is not disclosed to other employees of ***MSSC*** or other individuals in violation of this notice.

Other Uses and Disclosures of PHI

There are state and federal laws that may require or allow the Health Plan to release your health information to others. The Health Plan may provide information for the following reasons:

- **Health Oversight Activities:** The Health Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections, and licensure activities.
- **Legal Proceedings:** The Health Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.
- **Law Enforcement:** The Health Plan may disclose your protected health information to law enforcement officials under limited circumstances. For example, in response to a warrant or subpoena; for the purpose of identifying or locating a suspect, witness, or missing person; or to provide information concerning victims of crimes.
- **For Public Health Activities:** The Health Plan may disclose your protected health information to a government agency that oversees the health care system or government programs for activities such as preventing or controlling disease or activities related to the quality, safety, or effectiveness of an FDA- regulated product or activity.
- **Required by Law:** The Health Plan may disclose your protected health information when required to do so by law.
- **Workers' Compensation:** The Health Plan may disclose your protected health information when authorized by and to the extent necessary to comply with workers' compensation laws and similar programs.
- **Victims of Abuse, Neglect, or Domestic Violence:** The Health Plan may disclose your protected health information to appropriate authorities if the Health Plan reasonably believes that you're a possible victim of abuse, neglect, domestic violence, or other crimes.
- **Coroners, Funeral Directors, and Organ Donation:** In certain instances, the Health Plan may disclose your protected health information to coroners or funeral directors and in connection with organ donation.
- **Research:** The Health Plan may disclose your protected health information to researchers, if certain established steps are taken to protect your privacy.
- **Threat to Health or Safety:** The Health Plan may disclose your protected health information to the extent necessary to prevent or lessen a serious and imminent threat to your health or safety or the health or safety of others.

- **For Specialized Government Functions:** The Health Plan may disclose your protected health information in certain circumstances or situations to a correctional institution if you are an inmate in a correctional facility, to an authorized federal official when it's required for lawful intelligence or other national security activities, or to an authorized authority of the Armed Forces.
- **For Cadaveric Organ, Eye, or Tissue Donation:** The Health Plan may disclose your protected health information for the purpose of facilitating organ, eye, or tissue donation and transplantation.

Your Rights

You have the following rights regarding the protected health information that the Health Plan maintains about you.

- **You have the right to ask the Health Plan to restrict** its use and disclosure of protected health information for the purposes of treatment, payment, or health care operations. Your request must be in writing and sent to the claims administrator. If the information you for which you are requesting the restrictions involves health care services or supplies that were paid in full by you or on your behalf by another person, we will honor such request. Otherwise, the Health Plan will consider your request, but it is not required to agree to restrict the information.
- **You have the right to ask to receive confidential communications.** If you believe that normal communications would put you in danger, you may request that the Health Plan send communications with protected health information (e.g., an Explanation of Benefits) to you by alternative means or to an alternative location. Your request must be in writing and sent to the claims administrator. Your request must include the alternative location (e.g., fax number, address, etc.) to which you would like the Health Plan to send the information. Such requests, if reasonable, will be accommodated when you state in the request that you believe that normal communications would endanger you.
- **You have the right to inspect and obtain a copy** of the protected health information that the Health Plan maintains about you in a designated record set, including information maintained in paper or electronic formats. A designated record set contains protected health information that the Health Plan collects, maintains, or uses to administer or make decisions regarding your enrollment, payment, claims adjudication, or case management. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Access Request Form and send it to the claims administrator. An Access Request Form can be obtained by contacting the claims administrator or by downloading the form from the claims administrator's website. The Health Plan, or its designee, will respond within 30 days of the receipt of your request. The Health Plan may charge a reasonable, cost-based fee to provide you with the information. If you request such information be provided to you through unencrypted e-mail, you assume the risk on any unauthorized access or such protected health information during its transmission to you, and are responsible for safeguarding such information once it is delivered to you. There are exceptions as to what information can be accessed. For example, information compiled for legal proceedings cannot be accessed. If the Health Plan denies access to your information, in part or in whole, it will notify you in writing. The denial will include the reason for the denial, your review rights (if applicable), and information on how to file a complaint.
- **You have the right to ask the Health Plan to amend** protected health information about you that is contained in a designated record set (as described above) if you think that information is incorrect or incomplete. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Amendment Request Form and send it to the claims administrator. An Amendment Request Form can be obtained by contacting the claims administrator or by downloading the form from the claim administrator's website. Your request must include the reason for the request. The Health Plan, or its designee, may deny your request if you ask the Health Plan to amend information that: is not part of the protected health information kept by or for the Health Plan; was not created by the Health Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy; or is accurate and complete. If the Health Plan denies the request, you may file a written statement of disagreement with the Health Plan.
- **You have the right to request an accounting of certain disclosures** of protected health information. Your request must be in writing and must specify the time period for which you are requesting information. The period cannot start earlier than April 14, 2003, or go back more than six years from the date of your request. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Accounting Request Form and send it to the claims administrator. An Accounting Request Form can be obtained by contacting the claims administrator or by downloading the form from the claim administrator's website. The accounting will not include disclosures made to you or with your written authorization or in the course of treatment, payment, or health care operations. If you request such an accounting more than once in a 12- month period, the Health Plan will charge a reasonable fee.
- **You have the right to a copy of this notice** upon request. Your request must be in writing and sent to the Privacy Officer. A copy of the current notice will be sent to you.

For more information, or to begin the formal process connected with these rights, see Contact Information, below.

Contact Information

If you want to exercise any of the rights described in this notice with respect to the records held, or the disclosures made, by one of the Health Plan's claims administrators, you may contact that claims administrator.

- For matters concerning medical, dental, and vision benefits:
- For matters concerning prescription drug benefits:

Privacy Officer for MSSC

12060 Arlington Trail Arlington, TN 38002

(901) 389-2497 Ext. 2220

If you call a claims administrator, please tell the customer service representative that your call relates to the privacy of your protected health information.

If you have questions regarding this notice, you may also contact the Health Plan's Privacy Officer, c/o Arlington Community School's Benefits Dept., 12060 Arlington Trail, Arlington, TN 38002. You may also contact the Health Plan's Privacy Officer if you have any problems in exercising your rights.

Complaints

You have the right to file a written complaint with the Health Plan's Privacy Officer if you think your privacy rights have been violated. Include your name, address, and telephone number. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You won't be retaliated against or denied any Health Plan benefit or service because you file a complaint.

The Health Plan's Privacy Officer will investigate and address any issues of noncompliance with this notice of which any one or more of these entities or persons is notified or becomes aware.

Revisions to the Notice

MSSC reserves the right to change the terms of this notice and to make the new notice effective for all protected health information maintained by the Health Plan. ***MSSC*** will promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, the Health Plan's duties, or other practices stated in this notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new notice in which the material change is reflected.

Important Notice from Arlington Community Schools (*MSSC*) About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage with the **(MSSC)** may be affected. If you do decide to join a Medicare drug plan and drop your current **(MSSC)** coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the **(MSSC)** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the **(MSSC)** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1- 800-772-1213 (TTY 1-800-325-0778).

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

Date:	03-20-2022
Name of Entity/Sender:	**Arlington Community Schools**
Contact--Position/Office:	Employee Benefits Department
Address:	12060 Arlington Trail Arlington, TN 38002
Phone Number:	(901) 389-2497, Ext. 2220

Women's Health and Cancer Rights Act Enrollment Notice

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. Therefore, the following deductibles and coinsurance apply:

COPAY – Deductibles $0
Coinsurance 100% after copay met

If you would like more information on WHCRA benefits, call your Plan Administrator 901-389-2497, Ext. 2220.

NEWBORNS & MOTHER'S HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (901) 389-2497 Ext. 2220.

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL COVERAGE

If you have declined enrollment in a ***MSSC*** health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in the medical plan without waiting for the next open enrollment period, provided that you request enrollment within ***30 days after your other coverage ends***. 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 eligible dependents, provided that you request enrollment within ***30 days after the marriage, birth, adoption or placement for adoption.*** ***MSSC*** health plan will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in a ***MSSC*** health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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

MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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 12/31/2021)

Model General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan through Bartlett City Schools, known as "The Plan". This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Arlington Community Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to Arlington Community Schools; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits@acsk-12.org, along with verification of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please notify benefits@acsk-12.org.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Arlington Community Schools, Benefits Department
Benefits@acsk-12.org
12060 Arlington Trail
Arlington, TN 38002
901-389-2497, ext. 2220

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

Arlington Community Schools

NON-DISCRIMINATION NOTICE

Arlington Community Schools complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Arlington Community Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Arlington Community Schools provides:

- free aids and services to people with disabilities to communicate effectively with us;
- written information in other formats (large print, audio, accessible electronic formats, other formats); and
- free language services to people whose primary language is not English.

If you need these services, contact **Dr. Allison Clark**, Arlington Community School's Civil Rights Coordinator. If you believe that Arlington Community Schools has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Dr. Allison Clark, Arlington Community School's Civil Rights Coordinator or c all ACS Human Resources at 901-389-2497 Ext. 2022, or send a fax to 901-389-2499, or e-mail allison.clark@acsk-12.org.

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, Arlington Community School's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Dr. Allison Clark at 901.389.2497 Ext. 2022.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Dr. Allison Clark at 901.389.2497 Ext. 2022.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Dr. Allison Clark at 901.389.2497 Ext. 2022.
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Pennsylvania Dutch: Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call Dr. Allison Clark at 901.389-2497 Ext. 2022.

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر - 1-502-487-8205 Dr. Allison CLark at 901.389.2497 Ext. 2022.1 هاتف الصم والبكم: برقم الصم والبكم. اتصل بالمرجان

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Allison Clark at 901.389.2497 Ext. 2022.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Dr. Allison Clark at 901.389.2497 Ext. 2022.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Dr. Allison Clark at 901.389.2497 Ext. 2022.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Dr. Allison Clark at 901.389.2497 Ext. 2022.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Dr. Allison Clark at 901.389.2497 Ext. 2022.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Dr. Allison Clark at 901.389.2497 Ext 2022.

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Dr. Allison Clark at 901.389.2497 Ext. 2022.

Nepali: ध्यान दनुहोस: तपाइलेे नेपाल बोल्नहन्छ भन तपाइको ननम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ। फोन गनुहोसर Dr. Allison Clark at 901.389.2497 Ext. 2022.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 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 benefits@acsk-12.org; 901-389-2497, ext. 2220 .

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 ARLINGTON COMMUNITY SCHOOLS		4. Employer Identification Number (EIN) 46-4768276
5. Employer address 12060 ARLINGTON TRAIL		6. Employer phone number 901-389-2497
7. City ARLINGTON	8. State TN	9. ZIP code 38002
10. Who can we contact about employee health coverage at this job? Stephanie Moore, ACS Employee Benefits Specialist		
11. Phone number (if different from above) 901-389-2497 Ext. 2220	12. Email address benefits@acsk-12.org ; stephanie.moore@acsk-12.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:

Full-time employees who work in a year the average of 30 hours or more per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Children up to age 26 unless deemed handicapped, and spouses who are eligible through their employer, retired, unemployed, self-employed, or where their employer pays less than 50% of the total cost of the cheapest medical 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 09/01/2022 (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ **154.92**
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)