WASHINGTON
TOWNSHIP SCHOOLS

BENEFIT OFFERING for TRANSPORTATION STAFF

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Table of Contents

This guide is meant to summarize your available benefits. Official plan documents govern those benefits.

If there are any inconsistencies between the information in this guide and the plan documents, the plan documents will prevail.

Benefits are subject to change. You will be notified in writing of any changes.

This guide is not a contract for employment.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 28 for more details.

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Overview of Available Benefits

MSD of Washington Township (MSDWT) offers a comprehensive benefit package to all eligible Transportation staff:

- Employee Assistance Program (EAP)
- Medical and Prescription Drug coverage
- On-site IU Health & Wellness Center @ Northview Middle School
- Dental coverage
- Vision coverage
- Life insurance, including Accidental Death & Dismemberment coverage
- Short Term Disability Income Protection (STD)
- Tax-advantaged Savings Accounts (TSA):
    - Flexible Spending Accounts (FSA)
    - Dependent Care Accounts (DCA)
    - Health Savings Accounts (HSA)
- Retirement Savings Plans

Important Enrollment Information

Group Benefits (Medical/Rx, Dental, Vision, Life and AD&D)

You must enroll within 31 days of the date your benefits would be effective, if elected.
Even if you are declining all coverage, you must complete the enrollment process to indicate your decision.
If you decline a benefit or fail to complete the enrollment process within this time-frame, please note the following:

- Medical/Rx coverage will be unavailable to you until the next annual open enrollment period, or if you request to enroll within 31 days of a qualifying event. Please refer to Page 2 of this booklet for details regarding qualifying events.
- Dental coverage will be unavailable to you unless a qualifying event occurs and you enroll within 31 days of the event.
- Vision coverage will be unavailable to you unless a qualifying event occurs and you enroll within 31 days of the event.
- Life & STD insurance will be subject to approval by the carrier and requires proof of good health. You could be denied coverage.

All elected benefits are effective the 1st of the month following the date you are recommended for regular status.

Coverage for You and Your Dependents

In addition to yourself, you may also choose to cover eligible family members for health, dental, vision, and life insurance. Your eligible family members are:

- Your legal spouse, as defined by federal law.
- Your eligible children (includes a biological, adopted, or foster child, as well as a step-child):
    - Until the end of the month in which the child turns **26** for **medical**
    - Until the end of the year in which the child turns **25** for **dental**
    - Until the end of the year in which the child turns **25** for **vision**
    - Until the date the child turns **26** for **life insurance**

IMPORTANT NOTICE REGARDING HEALTH INSURANCE FOR YOUR SPOUSE:

Your spouse may only be covered on your health plan if they are:

- ***Unemployed***
- ***Retired***
- ***Self-employed***
- ***Employed, but their employer does not offer health insurance benefits to its employees.***

Qualifying Events for Enrolling at a Later Time

Some common scenarios employees ask about as they consider whether to enroll in insurance when it's initially offered to them:

1) I'm already covered under my parent's or spouse's employer plan. Can I enroll in the future?
2) What happens when my coverage ends under my parent's plan?
3) What if my spouse's employment status changes and their insurance ends?

HIPAA Qualifying Events and Special Enrollment Rights

If you decline medical, dental, or vision coverage for yourself or an eligible dependent or spouse, you may be able to enroll yourself or your eligible family member at a later date under the Special Enrollment Rights of HIPAA if you or the eligible family member experience a HIPAA qualifying event. Examples of a HIPAA qualifying event are:

- Birth, placement for adoption, or adoption of a child, or becoming subject to a Qualified Medical Child Support Order
- Marriage
- Loss of coverage under another employer's group plan due to:
    - A change in employment status
    - Loss of eligibility to continue to be covered (spousal carve-out, divorce, or death of a spouse)
    - The employer ceases to pay any portion of the premium, or ceases to offer coverage entirely

In order to enroll under the Special Enrollment provisions of HIPAA, you must request enrollment within 31 days of the date of the qualifying event. Coverage would be effective the date of the event.

If you miss the 31 day window, you may be able to enroll in health insurance during an annual open enrollment period as announced by the Director of Human Resources. For dental or vision you are only eligible to enroll within 31 days of a future qualifying event.

An Important Note Regarding State Assistance Plans

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- Coverage under Medicaid or CHIP (Children's Health Insurance Program) is terminated as a result of loss of eligibility
- Premium assistance for coverage under Medicaid or CHIP is approved by the State

It is your responsibility to notify Human Resources within **60 days** of the loss of Medicaid or CHIP coverage, or the date when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided on Page 29.

Employee Assistance Program (EAP)

What is EAP?

Our EAP, offered through **IU Health**, provides confidential assistance to you, your legal spouse, and your dependent children (up to age 26) to help resolve any concerns that are affecting your personal or work life. You and each family member may have ***six free visits*** with an EAP counselor each calendar year. **The District pays the full cost of this program.**

Why is the EAP being offered?

Usually we can work out issues on our own, but sometimes it can be beneficial to have an objective third party help us examine the situation. Issues that linger and remain unresolved can often start interfering with many different aspects of our lives: our relationships, job performance, and personal happiness - to name just a few.

What types of issues can the EAP assist with?

Personal coaching and professional assistance for many types of personal issues, including:

- Family and children concerns
- Marital or relationship conflicts
- Stress or other emotional difficulties
- Loss and grief issues
- Alcohol or other drug use

Will the District know if I use the EAP?

No! Using the EAP is confidential unless you choose to share with others. IU Health adheres to all laws governing confidentiality and will not release any information without your prior written permission to do so.

How much does the EAP cost?

Nothing! There is no out-of-pocket expense for either you or your eligible family member(s) to use the EAP.

How do I access the EAP?

Call (317) 962-8001 – 24 hours/day, every day of the year.

Common Insurance Terms & Their Definition

Common Term	Definition
Coinsurance	Coinsurance is a cost sharing agreement between you and the benefit plan (the Plan) in which the Plan pays a percentage of the covered costs after the deductible has been met and you pay the remaining balance up to a stated maximum out-of-pocket amount.
Copay	Copay is a fixed fee paid at the time of service. Unlike coinsurance, the deductible **does not apply** and copayments do not vary with the cost of a service. Copays count toward the out-of-pocket maximum **but do not count toward the deductible**.
Deductible	The deductible is the amount of covered expenses you're responsible to pay each calendar year before the Plan pays its share based on the coinsurance provisions of the Plan. **Expenses that go toward your deductible will also go toward your out-of-pocket maximum.**
PPO **Preferred Provider Organization**	A type of insurance arrangement that allows individuals the freedom to choose the doctors and hospitals they want to visit. Referrals are not required. Remember, however, that by staying inside the provider network you will typically have lower out-of- pocket expense and receive a higher benefit. If you choose to go outside the network, you'll have higher out-of-pocket expense and not all services may be covered.
Network Providers	Credentialed and contracted Providers are considered "In-Network" providers. These Providers have agreed to file your claim for you and to discount their fees.
Non-Network Providers	These Providers have no contract with the carrier and so they are not required to file claims or reduce their fees; they can demand payment from you before providing services.
In Network Coverage	Refers to the level of benefits received when you use Providers that have contracted with the carrier to provide discounted services.
Out-Of-Network Coverage	Refers to the level of benefits received when you use Providers that have not contracted with the carrier. You will experience higher out-of-pocket costs when using out-of-network Providers.
PCP **Primary Care Physician**	A non-specialist Physician who is responsible for coordinating your care. A Pediatrician is not considered a Specialist under our Plan. An OB-GYN is not considered a Specialist when providing wellness services.
OOP Max **Out-of-Pocket Maximum**	When an individual reaches the OOP max, all in-network charges incurred by that individual during the remainder of the calendar year will be covered in full by the Plan. Expenses that count toward the out-of-pocket maximum include all eligible charges that went toward the deductible, plus all co-payments, all eligible pharmacy expenses, and all coinsurance amounts.

Medical & Prescription Drug Coverage

Prescription Drug coverage is provided through a nationwide provider network with TrueScripts www.truescripts.com
With the exception of Walgreens/RiteAid, all pharmacies are in the TrueScripts network.

Our medical coverage is provided through a nationwide provider network with **Anthem** www.anthem.com
Utilizing Anthem network, participating healthcare providers agree to discount their fees and file claims on your behalf. When you obtain care from network providers you'll never pay the "retail" price so you'll save money because your share of the covered charges will be based on negotiated fees and the plan will pay a higher benefit.

We offer eligible employees the choice of two health plans:

Choice 1 - (Traditional Plan) with copays for day-to-day healthcare expenses
Choice 2 - (Qualified High Deductible Health Plan)
Employees enrolling in Choice 2 are eligible to contribute to a Health Savings Account (HSA)

Both plans include unlimited access to the IU Health & Wellness Center at Northview Middle School.

All services received at the Health & Wellness Center are *free of charge* to all individuals covered by our medical plan.

Both plans include access to a 24/7 Nurse Advice Line

Individuals covered by either medical plan may call (888-887-4114) to speak with a registered nurse regarding health-related questions or concerns. The nurse can help determine the appropriate level of medical care you may need. This free service can help you save time, money, and unnecessary trips to the emergency room -- and give you peace of mind!

NOTE: During Open Enrollment employees may re-evaluate their needs and change plans if they desire.

A Summary of Benefits and Coverage (SBC) for each medical plan, as well as a complete Summary Plan Document (SPD), may be found on the District's website www.msdwt.k12.in.us, located under the Human Resources section.

Did you know...

For children, a pediatrician is considered a primary care provider (PCP).
You'll pay the lower Primary Care Provider (PCP) copay
instead of the higher Specialist copay.
Additionally, you do not need prior authorization from Anthem
(or from any other person, including a PCP) in order to obtain care from a Specialist.

For information on participating network providers visit www.anthem.com

IU Health &Wellness Center @ Northview

Exclusively dedicated to school corporation employees and their families who participate in the health plan, the Health and Wellness Center at Washington Township provides convenient access to high-quality primary care at no out-of-pocket cost to you. The goal of the center is to help you stay well and live a healthier life.

Health and Wellness Center at Washington Township
8401 Westfield Blvd.
Door 19A South
Indianapolis, IN 46240

Hours
Please see benefits website for current hours
To schedule an appointment, visit msdwt.k12.in.us or call 317.253.4987 or dial ext. 22222 from work

Visit the Health and Wellness Center for a variety of services:

Preventive care

- Annual physicals and routine health exams
- Women's health exams – pelvic exams and pap smears
- Men's health exams – including prostate exams
- School and sports physicals
- Preventive screenings – blood pressure, blood sugar, cholesterol
- Immunizations – seasonal flu, hepatitis B, tetanus boosters
- Individual health coaching
- Nutrition counseling and wellness education

Immediate and primary care

- Diagnostic screenings – influenza, strep throat, vision, etc.
- Treatment of minor illnesses and injuries – sore throat, flu, seasonal allergies, stomach pain, sinus infection, eye infection, skin infection, rash, etc.
- Follow-up exams
- Management of chronic illnesses – diabetes, high blood pressure, COPD, high cholesterol, etc.

Lab services

- Screening and diagnostic labs as ordered by your doctor

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In collaboration with IU HEALTH Indiana University Health

Learn more about health coaching

Personal health coaching can help you make better lifestyle choices that can lead to a healthier life. The Health and Wellness Center's certified health coach will support you on your journey and provide accountability to help you achieve your health goals. Coaching sessions are scheduled at your convenience. During these one-on-one sessions, your health coach will help you:

- Develop an action plan based on your individual needs
- Build confidence and boost motivation for better health
- Turn your resolutions into reality

Frequently asked questions about the Health and Wellness Center

Who staffs the Health and Wellness Center?
The Health and Wellness Center at Washington Township is staffed by a board certified family practice physician and a medical assistant dedicated to helping you achieve your health improvement goals through medical care, personal consultations, health education and outreach.

How far in advance do I need to schedule an appointment?
While appointments are needed, you can schedule a same-day appointment, if one is available. In most cases, the healthcare team can see patients either the same day or within 24 hours. To schedule an appointment, visit msdwt.k12.in.us or call **317.253.4987, or dial ext. 22222 from work.**

What if I need to cancel an appointment?
Please advise the center in advance if you need to cancel or reschedule an appointment so others can reserve these appointment times.

Can my spouse and children visit the center for care?
If your spouse and children participate in the MSD Washington Township Health Plan, they can visit the center for services. For very young children (under age 2) and for childhood immunizations, we encourage you to seek care through a pediatrician.

Will the center work with my existing doctors, if necessary?
Yes. If you receive services in the center and want your healthcare information shared with the doctor or doctors you currently see, with a signed consent/release, the center will make sure your doctor receives all information about your visit.

What if I need to see someone when the Health and Wellness Center is closed?
We encourage you to seek care with your existing primary care provider. If you do not have one, please work with the center to get a referral. If your need is an emergency or an urgent matter, seek care through a local urgent care center or emergency room.

Can I get my medications at the center? Is there a cost for medications?
Certain medications are available **at no charge (including refills) when prescribed by the IU** Health and Wellness Center**.** If you have any questions about **this service**, feel free to call the **health** center or stop in to speak with a healthcare team member.

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In collaboration with IU HEALTH Indiana University Health

Medical & Prescription Drug Coverage, cont.

A detailed Summary of Health Benefits & Coverage may be found on the District website.

www.msdwt.k12.in.us, located under the Human Resources section.

Both plans include unlimited access to the IU Health & Wellness Center located at Northview Middle School

ALL SERVICES OBTAINED FROM THE HEALTH & WELLNESS CENTER PROVIDED FREE OF CHARGE

Dental Coverage

Dental coverage is provided through a nationwide provider network with **Delta Dental of Indiana** www.deltadentalin.com

Dental coverage helps to defray the cost of routine dental care and major services for you and your family.

- While all dentists designated as a **PPO or Premier** provider have agreed to discount their fees, you'll receive the ***steepest discount and a richer benefit*** when you obtain dental care from a **PPO** dentist.
- You may see any licensed dentist, even if they aren't in the Delta Dental provider network. However, the dentist may bill you for any amounts over the Usual & Customary charge. Also, the dentist is not required to file your claim for you and may demand payment in advance of providing services.

IMPORTANT NOTE: There are no orthodontic benefits for children or adults.

A detailed Summary of Dental Benefits & Coverage may be found on the District website.

www.msdwt.k12.in.us, located under the Human Resources section.

Vision Coverage

Vision coverage is provided through a nationwide provider network with **Vision Service Plan (VSP)** **www.vsp.com**
Vision coverage helps to defray the cost of your annual exam and corrective eye wear.
Each time you need vision care, you'll save money if you choose to obtain care from a VSP network provider.

A detailed Summary of Vision Benefits & Coverage may be found on the District website.

www.msdwt.k12.in.us, located under the Human Resources section.

Life & Accidental Death (AD&D) Coverage

Basic Life & AD&D Insurance

If something were to happen to you, what would your family do for income? With your district-sponsored life insurance benefit underwritten by **Sun Life Financial**, your family or other designated beneficiary can receive payment if you die.

- **The District will provide you with a specified amount of basic life insurance coverage at an annual cost of $1.**
- Coverage includes an accidental death & dismemberment benefit in the event you die or become injured in an accident.

Supplemental Insurance

You may elect to purchase additional coverage for yourself, and coverage for your legal spouse, at your own expense.

Information regarding the cost per paycheck will be provided to you during the enrollment process.

You may also elect to purchase life insurance for your **dependent children** (up to age 26) at your own expense without providing proof of good health.

Coverage amounts are **$5,000 per child**, or **$10,000** per child. The stated premium applies whether you insure 1 child or several children.

If you decline to enroll in basic coverage or to purchase supplemental coverage within 31 days of eligibility, you may apply for coverage at a later date as a Late Applicant, subject to underwriting approval by the carrier after providing proof of good health. *As a Late Applicant coverage could be denied.*

Important Information Regarding Life and AD&D Insurance

The employee's Basic Life and AD&D benefit amount will be **reduced at age 70 to 65%** of the principal amount.
All coverage terminates on the last day of employment or retirement.
The policy contains a provision to convert the coverage to an individual policy with the carrier upon request.

Tax Treatment of Your Life Insurance Benefit: According to Federal tax regulations, the first **$50,000** of your employer-provided life insurance coverage is not subject to taxes. Amounts over that amount are taxable. The federal government assigns a value to these amounts (called imputed income) and adds this to your W-2 earnings.

IMPORTANT NOTE
Upon death, life insurance proceeds are tax-free.
Beneficiaries do not pay taxes on life insurance proceeds.

Please refer to the Certificate of Coverage, posted on the District website, for full details of this valuable benefit.

Short Term Disability Income Protection

It's more likely that you'll experience a need to be off work due to a disability that doesn't last long enough for LTD to pay a benefit. Some examples are childbirth or elective surgery. Generally speaking, LTD benefits won't be payable because the time you need off work will be less than 90 calendar days.

For these types of short-term absences, you may wish to enroll in the short-term disability plan**.** This coverage, also underwritten by **Sun Life Financial,** will pay you a **weekly benefit equal to 60% of your weekly pre-disability base earnings for up to 11 weeks** after 15 calendar days of disability. Approval for benefits is based on medical documentation of disability as defined by the Certificate of Coverage.

PLEASE NOTE: The District **does not contribute** towards the cost of this coverage. You are solely responsible for 100% of the cost which is based on your annual salary and will be deducted via payroll deduction.
Because you pay 100% of the premium on a post-tax basis, benefits are not subject to withholding of local, state, or federal taxes.

You must enroll within 31 days of eligibility. Enrollment at a later date will require proof of good health and you could be denied coverage.

Please refer to the Certificate of Coverage, posted on the District website, for full details of this valuable benefit.

Tax Advantaged Savings Accounts

The District offers employees the ***option*** of contributing to one of two types of tax advantaged accounts governed by the IRS:

- Flexible Spending Accounts (FSA)
- Health Savings Accounts (HSA)

The funds in these accounts can be used to pay for qualifying unreimbursed healthcare expenses (medical, dental, and vision). Qualifying healthcare expenses typically include deductibles, copayments, coinsurance, and goods or services not covered by medical, dental, or vision insurance.

Although the accounts differ in many ways, both accounts provide tax savings because the money contributed to the account from your bi-weekly earnings via payroll deduction is not considered part of your adjusted gross income and therefore are tax-exempt. No taxes are paid on the earnings you redirect to these accounts. And no taxes are paid on funds withdrawn/used to pay for qualifying healthcare expenses.

Flexible Spending Accounts (FSA)

FSAs are tax advantaged ***employer-established*** arrangements that reimburse employees for qualifying healthcare expenses. FSAs are funded through a Salary Reduction Agreement in compliance with Section 125 of the Internal Revenue Code. **Employees may elect to redirect a portion of their bi-weekly earnings to an FSA regardless of whether they are enrolled in any of the MSDWT insurance programs.**

Health Savings Accounts (HSA)

HSAs are tax advantaged accounts ***established by individuals*** to set aside funds for payment of qualifying healthcare expenses. To be eligible to contribute to an HSA you must be covered by a qualified high deductible health plan (HDHP) that meets specific IRS criteria regarding deductible and out of pocket levels. **Only the Choice 2 medical plan meets these criteria.**

By law, you MAY NOT contribute to *both* a Flexible Spending Account and a Health Savings Account.

Please refer to Pages 14 through 17 for complete details regarding these accounts.

Flexible Spending Accounts

A **F**lexible **S**pending **A**ccount (FSA) is a **spending account** funded with money you set aside from your paycheck before income taxes are calculated based on your remaining earnings. You may set up a spending account for **Health Care**, **Dependent Daycare**, **or both**. **You are not required to be covered under our insurance in order to contribute to a FSA.**

- Claims for Health Care Reimbursement and/or Dependent Care Reimbursement are administered by HealthEquity.
- Participants will be provided a Debit Card(s).
- You may also submit claims on-line via the HealthEquity website, by fax or through U.S. Mail.
- You may elect to have the reimbursement deposited directly to your checking account.
- Claim and reimbursement information is available on-line or by touchtone phone 24 hours a day, 7 days a week.

Health Care Expenses

You may set aside an amount of your salary within IRS regulations **per calendar year**. These funds can be used to pay for a variety of eligible expenses such as:

- Deductibles, copays, coinsurance, and prescription drug costs
- Expenses not covered by any health, dental, or vision insurance plan
- Certain over-the-counter items obtained for you or your dependent(s) health care needs
- Expenses in excess of medical or dental coverage limits, such as your share of orthodontia treatment costs

Funds may be used for your own eligible expenses as well as the eligible expenses of your spouse or dependent children - *even if they aren't covered on your insurance plan*.

Dependent Day Care Expenses

This account is designed to help you pay for dependent day care expenses so you and/or your spouse can work. You also can use the account to pay adult day care expenses for a spouse who is mentally or physically handicapped. You may set aside an amount of your salary within IRS regulations **per year**. **If you are married and your spouse also contributes to a similar account through their employer, you & your spouse combined may set aside no more than the maximum that the IRS allows per year**.

Eligible dependent day care can be provided in your home or in someone else's home, or in a care facility (except for a nursing home). When you submit a claim for expenses, you must provide your care-giver's tax identification number (for individuals, this usually is their Social Security Number). Generally, your eligible dependents include:

- Children under age 13 who qualify as a dependent on your federal income tax return
- Dependents unable to care for themselves (e.g., an incapacitated older child, spouse, or elderly parent who regularly spends at least eight hours a day in your home and otherwise qualifies as a dependent under IRS rules)

Open Enrollment to participate in the Flexible Spending Program occurs each Fall. You must re-enroll every year.

HR will send an email to all staff with enrollment details.

Flexible Spending Accounts, cont.

Special Rules Under S125 of the Internal Revenue Code

Because the spending accounts provide significant tax savings, the IRS imposes restrictions that we want you to be aware of so that you can make an informed decision about whether to enroll:

- Each account is completely separate. You may not transfer money from one account to another. You also may not use your health care account to pay for dependent day care expenses, or your dependent day care account to pay for healthcare expenses.
- If you claim an expense for reimbursement through either account, you may not claim the same expense as a deduction or a credit on your income tax return.
- On January 1st your FSA will be credited with the full amount of funds you agreed to set aside even though you haven't actually contributed those funds yet.
- For dependent day care reimbursement, funds are only available to the extent that funds have been contributed from your bi-weekly paycheck.
- Dependent day care enrollment requires that you file **IRS Form 2441** with your federal return. The form is simply an informational form to report the amount you paid and to whom.
- You have until March 31st to submit healthcare or dependent day care expenses incurred during the prior calendar year (expenses must be incurred between January 1 and December 31 of the prior year.
- **Unspent funds are forfeited and cannot be returned to you. Use it ...or Lose it!**

Worksheet

Annual Expenses	Es mated Amount
Medical plan deductibles	$
Medical plan copayments	$
Prescription drug copayments	$
Other expenses (such as prescribed over-the-counter drug costs)	$
Dental deductibles	$
Dental copayments	$
Orthodontia copayments/amounts exceeding limit	$
Vision care expenses	$
Total expenses	**$**
Total you wish to contribute	$
In order to determine your per pay contribution, divide your total contribution by 24 pays (or 18 if you signed up for 18 pays).	$

Health Savings Accounts

A **H**ealth **S**avings **A**ccount (HSA) is a **savings account** funded with money you set aside from your paycheck before income taxes are calculated based on your remaining earnings. **Only those employees enrolled in the Choice 2 qualified high deductible health plan** (also known as the **HSA plan**) may contribute to an HSA.

Who can benefit from an HSA eligible plan?

Those who will benefit most are those who are willing to:

- Systematically fund the savings account through payroll deduction
- Take an educated consumer approach by comparing costs, evaluating urgency/frequency of appointments, etc.
- Maintain receipts and other records (IRS requirement)
- Adjust to a new way of managing healthcare expenses

Please note: The District does not contribute to the HSA. By enrolling in the HSA plan and reducing what's deducted from your paycheck for coverage when compared to the per pay cost for the Choice 1 plan, you can use the savings to fund your HSA on a tax-advantaged basis.

Are there any tax or other financial benefits to enrolling in an HSA eligible plan*?*

- Individual contributions to an HSA (up to IRS maximums) are not subject to income taxes, thus reducing your taxable income. IRS limits can change each year. Please consult the IRS website for details.
- Debit cards, checks and on-line transfers are available for withdrawals from your HSA.
- HSA funds remain in the individual's account from year to year until they are used -- **funds are never forfeited**.
  A change in employer or a change in enrollment does not affect your ability to continue to use the funds.
- An HSA is designed to pay for medical, dental, vision, and RX expenses -- now, or in the future.
  Funds can be used throughout the year or left to accumulate in the account for future needs.
- Withdrawals for qualified medical, dental, vision, and RX expenses are tax free.
- Qualified expenses are those expenses not typically covered by insurance coverage (e.g., laser eye surgery, hearing aids, orthodontia, etc.). Visit **http://www.irs.gov/publications/p502/index.html** for a complete list.
- The same types of investments permitted for IRAs are allowed for HSAs including stocks, bonds, mutual funds and certificates of deposit.
- The account holder controls all decisions over how the money is invested.
- The interest earnings on assets in the account grow tax free.

Additional information is available through several excellent websites:

www.thehsaauthority.com or **www.hsabank.com**

http://www.irs.gov/publications/p969/index.html

Health Savings Accounts, cont.

About Our Qualified High Deductible Health Plan - the Choice 2 Plan (an HSA Eligible Plan)

- The plan meets all IRS criteria with regard to the deductible and the out-of-pocket maximum.
- Per IRS rules, other than preventive care and services obtained from the on-site IU Health & Wellness Center, all benefits are subject to the deductible. This means that other than preventive care and services obtain from the IU Health & Wellness Center, before the plan pays for an individual's eligible healthcare expenses the individual must first satisfy a deductible. ***Remember: you will be paying negotiated fees that reflect a significant discount over retail.***

Other Important Details You Should Know

As the owner of the account, you are responsible for compliance with all IRS regulations as described in IRS Publication 969 (available on the IRS website at **http://www.irs.gov/publications/p969/index.html**).

To be eligible to contribute to an HSA, an individual must:

- Be covered by our Choice 2 plan, which is a qualified high deductible health plan
- Not be covered by another health plan that is not a qualified high deductible plan
- Not be enrolled in Medicare

Worksheet

Annual Expenses	Es. mated Amount
Medical plan deductibles	$
Medical plan copayments	$
Prescription drug copayments	$
Other expenses (such as prescribed over-the-counter drug costs)	$
Dental deductibles	$
Dental copayments	$
Orthodontia copayments/amounts exceeding limit	$
Vision care expenses	$
Total expenses	**$**
Total you wish to contribute	$
In order to determine your per pay contribution, divide your total contribution by 24 pays (or 18 if you signed up for 18 pays).	$

Note: The amount you contribute to an HSA through payroll deduction can be changed at any time by providing Payroll with an updated HSA Payroll Authorization Form, found on the District website.

Retirement Benefits

An important aspect of achieving financial well-being is retirement planning. The District provides several retirement plans.

403(b) Savings Plan

What is a 403(b) plan?

A 403(b) plan (also called a **T**ax-Sheltered **A**nnuity plan (TSA) is a retirement savings plan offered by public schools and certain 501(c)(3) tax-exempt organizations. The name simply refers to the section of the tax code which governs such plans. The District offers a 403(b) plan through **AIG (formerly known as VALIC)**. Employees contribute to individual accounts which include a variety of investment options.

What are my next steps?

- Meet with an AIG registered representative to review investment options and make your investment elections.
- Complete an enrollment form to open your account and authorize payroll deductions of your contributions.
  You must enroll so your account can be created, otherwise your payroll deducted contributions can't be deposited.

Important Notes:

Vesting requirements apply.

Retirement Benefits cont.

401(a) Savings Plan

What is a 401(a) plan?

A 401(a) plan provides you with an additional way to save toward retirement. The name simply refers to the section of the tax code which governs such plans. The District offers a 401(a) savings plan through **MetLife** and employees contribute to individual accounts which include a variety of investment options.

Why should I contribute to a 401(a) plan?

When you enroll in the 401(a) plan, the District will contribute an amount equal to **1.85%** of your base contract.

What are my next steps?

- Meet with a MetLife registered representative to review investment options and make your investment elections.
- Complete an enrollment form to open your account and authorize payroll deduction of your contributions.
  You must enroll so your account can be created, otherwise your payroll deducted contributions can't be deposited.

Important Notes:

Vesting requirements apply.

Retirement Benefits cont.

VEBA Retiree Healthcare Savings Account

What is a VEBA?

A VEBA is a 501(c)(9) Trust that is funded with a **H**ealth **R**eimbursement **A**ccount (HRA). The name simply refers to the section of the tax code which governs such plans. The District offers a VEBA plan, with a variety of investment options, through Indiana HRA**.** While a VEBA plan is designed to provide funds to cover healthcare expenses during retirement, once you separate employment from MSD Washington Township you may access the funds at any time if you have satisfied the vesting requirements.

The District will contribute an amount equal to 1.5% of your base contract, submitted on a bi-weekly basis.

You will be automatically enrolled; no enrollment form is required.

Important Notes:

Vesting requirements apply.

Retirement Benefits cont.

Indiana Public Retirement System (INPRS) aka Public Employee Retirement Fund (PERF)

What is INPRS?

INPRS oversees the administration of the various State retirement funds for public employees, including the Teachers Retirement Fund (TRF). The fund is a retirement account designed to help you achieve financial well-being.

As a public school employee, you are automatically a member of INPRS and will have an individual **A**nnuity **S**avings **A**ccount (ASA) funded by a 3% mandatory contribution. Per state law, contributions are paid either by the member via payroll deductions or by the employer on the member's behalf. **If you are eligible, the District will contribute the entire 3% on your behalf, submitted on a bi-weekly basis. You will not be responsible for any of the 3% contribution. Your HR Coordinator can confirm whether you are eligible for PERF.**

What are my next steps?

- Visit **www.in.gov/inprs** to log into your account and review the accuracy of all personal information shown.
- Keep your INPRS account updated (beneficiary changes, name change, address changes). **Only you can make these changes.**

Important Notes:

Vesting requirements apply. Please visit **www.in.gov/inprs** for details.

Legal Notices

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the Guide, the Benefit Plan Notice Requirements document, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. MSD Washington Township (MSDWT) reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Summary of Material Modification

The information in this document and in the benefit guide applies to the MSDWT Benefit Plan. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you may have recently become eligible for coverage under the MSDWT Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation on coverage, when it may become available to you and your family, and what you need to do to protect**

Legal Notices, cont.

the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is MSD Washington Township. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. 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 the health plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For 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 send this notice to: MSDWT Human Resources. You must include the address of the former dependent with your notification.

Legal Notices, cont.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to **36 months**.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to **18 months**. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18 month period of COBRA continuation coverage. This notice should be sent to: MSDWT Human Resources/Benefits Department. A copy of the Social Security Administration's determination letter should be provided with notification.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child is no longer eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: MSDWT Human Resources/Benefits Department.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact MSDWT Human Resources Department or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Legal Notices, cont.

Family and Medical Leave Act Rights and Responsibilities

MSD of Washington Township ("MSDWT") is covered by the Family and Medical Leave Act of 1993 (FMLA) Employees are eligible for the leave if they have been employed with the District for at least twelve (12) months and have worked at least 1,250 hours during the twelve (12) month period before the earlier of the date the employee requests or the date the leave commences. Additionally, to be eligible employees must work at a worksite with fifty (50) or more employees within a seventy-five (75) mile radius of the worksite.

The FMLA requires the District to provide eligible employees with up to twelve (12) weeks of unpaid leave during a twelve (12) month period for any one (1) or more of the following reasons:

1. For birth of a child, and to care for the newborn child;
2. For placement with the employee of a child for adoption or foster care;
3. To care for the employee's spouse, child or parent (biological or adoptive, not in-law) with a serious health condition; and
4. Because of a serious health condition that makes the employee unable to perform the essential functions of the employee's job;
5. For qualifying exigencies arising out of the fact that the employees' spouse, son, daughter or parents is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent or next of kin of a current member of the Armed Forces, including a member of the National Guard or reserves, with a serious injury or illness up to a total of **26 weeks** of **unpaid** leave during a "single 12-month period" to care for the service member.

Spouses employed by the same employer are limited in the amount of family leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition to a combined total of 12 weeks (or 26 weeks if leave to care for a covered service member with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Leave under 1 and 2, above, must be taken within twelve (12) consecutive weeks, and must be taken before the end of the twelve (12) month period commencing on the date of birth or placement. Leave under 3 or 4, above, may be taken intermittently or on a reduced time basis (e.g., by working fewer days in a week or fewer hours in a day) but only if such a schedule is medically necessary.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (i.e., inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**
- Continuing treatment by a health care provider, which includes:
    1. A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also includes:
        - Treatment two or more times by or under the supervision of a health care provider (i.e., in-person visits, the first within 7 days and both within 30 days of the first incapacity); **or**
        - One treatment by a health care provider (i.e., an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (e.g., prescription medication, physical therapy); **or**
    1. Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

Legal Notices, cont.

2. Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**
3. A period of incapacity that is permanent or long term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**
4. Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

Any determination whether a situation involves entitlement to FMLA leave will be ultimately determined and governed by reference to the Act, itself, together with applicable regulations and interpretive decisions.

If a husband and wife work for MSDWT, the two are limited to a total of twelve (12) workweeks if the leave is for the birth, adoption, or foster care of a child, or to care for a sick parent.

Leave Integra on

Except for maternity leave of 6 weeks (8 weeks if cesarean section), an employee must substitute paid leave during an otherwise unpaid FMLA Leave. Also, FMLA Leave will run concurrently with paid leave so long as the reason for such leave also constitutes an FMLA-qualifying reason.

Return to Work

Upon return from a FMLA Leave, an employee will be reinstated to the same or equivalent position with equivalent pay and benefits, but has no greater right to such reinstatement than the employee would have enjoyed had the employee been actively employed rather than on FMLA Leave.

To prevent serious economic injury to the District, the District may deny reinstatement to an exempt employee who is among the highest paid 10% of all employees. The District must notify the employee of its intent to deny reinstatement either before or during the leave and must offer the employee a reasonable opportunity to return to work from FMLA Leave after giving this notice, and make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration.

Intermittent or Reduced Schedule Leave

If an employee requests intermittent leave or a reduced leave scheduled for a serious health condition reason that is foreseeable based on planned medical treatment, the District may require the employee to transfer temporarily to an available alternative position that has equivalent pay and benefits and better accommodates recurring periods of leave than the regular position.

Group Health Care Benefits

Group health care benefits will continue during the FMLA Leave, on the same basis as if the employee were actively at work, including provisions relating to payment of contributions, deductibles and co-pays by the employee, and further including any changes in such benefits or terms which occur during the FMLA Leave. The District shall have the right to recover the premiums paid for maintaining coverage for the employee under such group health care plans during the period of the FMLA Leave if the employee fails to return to work for reasons other than the continuation, recovery, or onset of the serious health condition which entitled the employee to the FMLA Leave, or due to other circumstances beyond the employee's control.

Employee Notice Requirements

When the need for a FMLA Leave is foreseeable based upon an expected birth, placement for adoption or foster care, or planned medical treatment for a serious health condition of an employee or family member, the employee must provide the District with thirty (30) days notice before the leave is to begin or as soon as practical, taking into account all relevant facts and circumstances. If the requested leave is for planned medical treatment for a serious health condition, the employee must consult with the District and make a reasonable effort to schedule the treatment leave so as not to unduly disrupt District operations, subject to approval by the health care provider. Similar efforts must be made where the employee requests intermittent or reduced time FMLA leave.

Legal Notices, cont.

When the need for or timing of a FMLA Leave is not foreseeable, the employee should notify the District of the need for the leave as soon as practical under the facts and circumstances of the situation, ordinarily within one (1) or two (2) days of learning of the need for the leave. Failure to provide the required notice may result in a delay in the taking of the FMLA Leave until notice requirements have been met.

An employee on an approved FMLA Leave is also required to report to the District periodically [at least every thirty (30) days] on the employee's status and intent to return to work, as well as of any changed circumstances **affecting the amount of FMLA Leave originally anticipated.**

Medical Certification

The District requires that medical certification be provided to support any FMLA Leave request involving a serious health condition of the employee, his/her spouse, child or parent. The certification must be provided by the health care provider of the employee or affected family member. The medical certification should be provided prior to the commencement of the leave when the leave is foreseeable and at least thirty (30) days notice has been provided, or within fifteen (15) days of the District's request in other circumstances. Required medical certification information includes a description as to how the serious health condition meets FMLA criteria, the commencement and probable duration of the same and any resultant incapacity, whether an intermittent or reduced time leave schedule is medically necessary and its probable duration, the anticipated treatment by the health care provider (or other health care providers) and, if a serious health condition of the employee is involved, the employee's ability to perform work of any kind or one or more of the essential functions of the employee's position. Forms for providing required medical certification information will be mailed to the employee's home by the Human Resources Benefits Specialist.

In addition, if the requested leave is to care for a spouse, child or parent who has a serious health condition, the employee must provide medical certification from the family member's health care provider describing the care or assistance (medical, personal, safety, transportation or other) that the employee will be providing, including the time period or schedule and duration. Medical certifications must be updated every thirty (30) days [unless the initial certification indicated the minimum duration of the period of incapacity was greater than thirty (30) days] and in the event of significant changed circumstances or where questions arise as to the reasons for the employee's absence. The employer may require that the eligible employee obtain subsequent recertification on a reasonable basis.

The District may require, at its expense, second and third medical opinions from different health care providers as permitted under and subject to the conditions of the FMLA.

The District also requires that the employee provide a fitness for duty medical certification (return to work order) from the employee's health care provider(s) prior to return to work from a FMLA Leave involving a serious health condition of the employee where the employee has been off of work for four (4) or more days. The District may also require a fitness for duty certification in other circumstances where warranted. Return to work will be delayed until the same is provided.

Conflicts

The foregoing provisions are intended to comply with the Family and Medical Leave Act of 1993, and any terms used herein will be as defined in the Act. To the extent that any of the foregoing provisions afford less benefits than the Act, or the event of any other conflict, the provisions of the Act shall prevail.

Medicare Part D Notice

Important Notice from MSD of Washington Township (MSDWT) About Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information on about your current prescription drug coverage with MSDWT 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. Informa on about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverageif you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **MSDWT has determined that the prescription drug coverage offered by MSDWT 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 MSDWT coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current MSDWT coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 MSDWT 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.

Medicare Part D Notice, cont.

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 19 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 Informa on 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 MSDWT changes. You also may request a copy of this notice at any time.

For More Informa on About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" hand-book. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medi-care 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 infor-mation 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).

Name of Sender:	**MSD of Washington Township**
Contact Name & Position:	**Jennifer Schuler, Benefits Specialist**
Office Address:	**8550 Woodfield Crossing Blvd.**
	Indianapolis, IN 46240
Phone Number:	**317-845-9400**

Medicaid & Children's Health Insurance Program (CHIP)

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 are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual 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, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, 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 are not 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, 2015. You should contact your state for further information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

Medicaid & Children's Health Insurance Program (CHIP)

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs/state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.eohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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

WASHINGTON – Medicaid
Website:
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022, ext.15473

WEST VIRGINIA – Medicaid
Website:
http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/ default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Telephone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

- U.S. Dept. of Labor, Employee Benefits Security Administration: www.dol.gov/ebsa
  Phone: 1-866-444-EBSA (3272)
- U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: www.cms.hhs.gov
  Phone: 1-877-267-2323, menu option 4, extension 61565

Contact Information for Group Benefits

Anthem ..... **(800) 981-6731**
www.anthem.com

TrueScripts (RX) ..... **(844) 257-1955**
www.truescripts.com

Delta Dental ..... **(800) 524-0149**
www.deltadentalin.com

VSP (Vision Service Plan) ..... **(800) 877-7195**
www.vsp.com

EAP (Employee Assistance Plan) ..... **(317) 962-8001**
www.iuhealth.org/employee-assistance

IU Health & Wellness Center at Northview Middle School ..... **(317) 253-4987**

Contact Information for Voluntary Benefits

Aflac (accident / critical illness / hospitalization) ..... **(800) 443-3036**

Sun Life Financial (short-term disability) ..... **(800) 247-6875**
www.sunlife.com/us

Trustmark (universal life) ..... **(877) 918-8877**

HealthEquity (Health Care Spending & Dependent Day Care) ..... **(866) 735-8195**
www.HealthEquity.com

Contact Information for Retirement Info

MetLife ..... **(317) 818-1913**

AIG (VALIC) ..... **(317) 818-5900**

INPRS ..... **(844) 464-6777**

Other Questions?

Jennifer Schuler, Benefits Specialist - jschuler@msdwt.k12.in.us ..... **(317) 205-3332, x77280**