



Sharon Community School
2023 Employee Benefits Guide

Benefits Enrollment Checklist

This guide will help you get to know your benefits and your choices for the 2022 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

During Enrollment

Enroll in these plans or waive coverage:

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Life Insurance and AD&D
- Long Term Disability







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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your employer. It does not include all of the terms, coverage, exclusions, limitations and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request. The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issue. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



Carrier Contacts



<i>Coverage</i>	<i>Carrier</i>	<i>Contact</i>
Medical	MercyCare Health	800.895.2421 https://mercycahealthplans.com
Flexible Spending Account	EBC	800.346.2126 participantservices@ebcflex.com www.ebcflex.com
Dental	Delta Dental of WI	800.236.3712 claims@deltadentalwi.com www.deltadentalwi.com
Vision	Delta Vision	800.236.3712 www.deltadentalwi.com
Life Insurance & AD&D	The Standard	888.937.4783 www.standard.com
Long Term Disability	The Standard	888.937.4783 www.standard.com

Medical Plans

Medical Plans

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family. Sharon Community Schools provides eligible employees the choice of 3 medical plans administered by MercyCare Health Plan.

- The Higher Deductible Health Plan offers the lowest premiums, but you'll have a higher deductible and will pay more before the plan starts to cover some of your costs.
- The Traditional Plan has higher premiums compared to the Higher Deductible Health Plan offering. This plan also has copays, which means you'll pay more upfront in premiums but less for your medical services when seeking care.

You have the freedom to receive care from any licensed provider. However, you generally pay less when you receive care from doctors, hospitals and other health care facilities that participate in the MercyCare network.

Find a participating health care provider in your area by going to:

<https://mercyhealthsystem.org/our-physicians/#!/physician>

Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

Eligibility

- All full-time employees

And Your...

- Spouses
- Biological children, stepchildren, legally adopted children (effective from the placement date for adoption), and foster children up to age 26.

Terms To Know

Deductible

The amount **you pay** out of your pocket each year **before the plan begins** sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

Copay

The dollar amount you must pay for certain covered services. Payments count toward your annual out-of-pocket maximum but **not** toward your deductible.

Out-of-Pocket Maximum

The most you'll have to pay out of your pocket in a calendar year for covered services.

Coinsurance

The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan. The plan covers the percentage of the expense shown.

Medical Plan Highlights





MERCYCARE	OPTION 1: \$500 Traditional HMO <i>Embedded Deductible</i>		OPTION 2: \$1500 HMO <i>Embedded Deductible</i>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE				
Single	\$500		\$1,500	
Family	\$1,000		\$3,000	
OOPM		No Coverage		No Coverage
Single	\$1,000		\$7,150	
Family	\$2,000		\$14,300	
COINSURANCE	0 %		10 %	
	IN-NETWORK COVERAGE		IN-NETWORK COVERAGE	
PREVENTIVE CARE	<i>Select Services Are NO COST</i>		<i>Select Services Are NO COST</i>	
PHYSICIAN SERVICES				
Virtual Care		\$0 Copay		\$0 Copay
Primary Care		\$10 Copay		\$30 Copay
Specialty Care		\$10 Copay		\$30 Copay
Urgent Care		\$25 Copay		\$60 Copay
HOSPITAL SERVICES				
Inpatient / Outpatient		Deductible Applies		Deductible & Coinsurance
EMERGENCY CARE <i>Copay Waived if Admitted</i>		Copay, and/or Deductible & Coinsurance \$150 Copay		Deductible & Coinsurance \$125 Copay
	IN-NETWORK COVERAGE		IN-NETWORK COVERAGE	
PRESCRIPTION DRUGS				
Out-of-Pocket Maximum				
Single		Applies Towards Medical		Applies Towards Medical
Family		Out-of-Pocket Maximum		Out-of-Pocket Maximum
Retail 30 Day Supply				
Tier 1		\$5		\$10
Tier 2		\$20		\$25
Tier 3		\$40		\$50
Tier 4		Not Covered		Not Covered

Refer to the Certificate of Coverage or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

Monthly Rates	Option 1: \$500 Traditional HMO	Option 2: \$1500 Higher Deductible HMO
Employee	\$103.84	\$30.76
Family	\$230.50	\$68.30

Understanding Your Care Options

Proactively understanding your care options can have a big impact in the amount you pay out-of-pocket when seeking care. The chart below is intended to help you identify the right setting for your specific needs.

Type of Care	Common Services	Approximate Wait Time	Member Cost
Virtual Care 	<ul style="list-style-type: none"> ○ Colds or flu ○ Bronchitis ○ Respiratory infection ○ Pink eye ○ Sinus problems ○ Allergies ○ Urinary tract infection ○ Poison ivy 	15-20 Minutes	\$0 Use code: STAYHEALTHY
Primary Care 	<ul style="list-style-type: none"> ○ Preventative services ○ Vaccinations ○ Medical problems that are not an immediate, serious threat to your health or life 	1 Week or More	\$10 Copay (HMO & PPO Traditional) \$30 Copay (HMO Higher Deductible)
Urgent Care 	<ul style="list-style-type: none"> ○ Sprains or strains ○ Mild asthma attack ○ Sore throat ○ Earaches ○ Minor broken bone ○ Minor cut ○ Minor infection ○ Minor rash 	20 – 30 Minutes	\$25 Copay (HMO & PPO Traditional) \$60 Copay (HMO Higher Deductible)
Emergency Room 	<ul style="list-style-type: none"> ○ Sudden change in vision ○ Sudden trouble talking ○ Large open wounds ○ Major burn ○ Severe head injury ○ Heavy bleeding ○ Chest pain ○ Major broken bone 	3 – 12 Hours	\$150 Copay (HMO & PPO Traditional) \$125 Copay (HMO Higher Deductible)

Flexible Spending Account (FSA)

With an FSA, you can set aside tax-free money to pay for eligible medical and dependent care expenses. When you participate in an FSA, you decide how much you want to contribute each plan year* (July 1 through June 30). The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!*** However, you must use the amounts in your account by the end of the plan year or lose the balance.

Sharon Community Schools offers two types of FSAs administered by Employee Benefits Corporation

Traditional Healthcare FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. You're ***not*** eligible for the Healthcare FSA if you are currently contributing to a Health Savings Account.

NOTE: The Healthcare FSA plan year is July 1, 2023 – June 30, 2024.

Health Care FSA Contribution Limits

Sharon Community Schools follows the indexed contribution limits set for this type of account by the Internal Revenue Service (IRS). The contribution limits for the Healthcare FSA work on an individual employee/financial representative basis. The individual maximum is \$3,050. However, if you and your spouse are both eligible for the same employer's FSA, you can each contribute separately to have your own \$3,050 cap.

Dependent Care FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of \$5,000 per year. Individuals who are married and file taxes separately can contribute up to a maximum of \$2,500. You ***cannot*** contribute more than you or your spouse earned in income for the year. ***If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.***

FLEXIBLE SPENDING ACCOUNT ROLLOVER PROVISION

Sharon Community School's Medical Flexible Spending plans have a rollover provision that allows unused balances of **up to \$610** to roll into the next plan year. Anything above \$610 will not carryover beyond June 30th.

Dental Plan Highlights

Healthy teeth and gums are an important part of maintaining your overall health. That's why Sharon Community School offers two dental plans administered by Delta Dental of Wisconsin.

Delta Dental of WI

Individual Annual Maximum	\$2,000
Deductible	
Employee Only	\$0
Family	\$0
Preventive Care Services	
Exams	100%
Cleanings	100%
Fluoride Treatments	100%
X-Rays	100%
Space Maintainers	100%
Basic Restorative Services	
Sealants	80%
Emergency Treatment to Relieve Pain <i>(Deductible Applies)</i>	80%
Fillings	80%
Endodontics – Surgical / Non-Surgical	80%
Periodontics – Surgical / Non-Surgical	80%
Extractions – Surgical / Non-Surgical and other oral surgery <i>(Deductible Applies)</i>	80%
Repairs and Adjustments to Bridges and Dentures	80%
Major Restorative Services	
Crowns, Inlays, Onlays	80%
Bridges and Dentures	80%
Implants	No Coverage
Orthodontic Services	
Coinsurance	50%
Individual Lifetime Maximum	\$1,500
Dependents Eligible to Age	26
Adult Orthodontia	Yes

Refer to the Summary Plan Description (SPD) for detailed dental plan coverage information.

Bi-weekly Rates	Employee Cost
Employee	\$0
Family	\$0

Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more. That's why Sharon Community School provides vision care administered by Delta Vision.

Delta Vision by EyeMed	In-Network	Out-of-Network
Frequency		
Vision Exam	Once per 12 months	
Frame	Once per 24 months	
Lenses	Once per 12 months	
Annual Vision Exam	\$10	\$20
Contact Lens (fit and follow-	\$25	\$20
Allowance Summary		Up To
Frames	\$120 Retail Allowance	\$60
Single Vision Lenses	Member pays \$25, plan pays balance	\$25
Bifocal Lenses	Member pays \$25, plan pays balance	\$40
Trifocal Lenses	Member pays \$25, plan pays balance	\$55
Conventional Contacts	\$135 Retail Allowance	Not Covered

Refer to the Certificate of Coverage or for detailed vision plan coverage information.

Monthly Premiums	Employee Cost
Employee	\$5.32
Employee + Spouse	\$10.64
Employee + Child(ren)	\$10.86
Family	\$16.16

Protection Plans

Long Term Disability (LTD)

Sharon Community School's Long-Term Disability plan is administered by The Standard and paid for by Sharon Community Schools. This benefit pays a *monthly* percentage of your salary if you become disabled and are unable to work for an extended period of time.

Carrier Name	Benefit Highlights
Premium	Employer Paid
Monthly Benefit	75% to \$7,875
Elimination Period	60 Days
Maximum Benefit Duration	Until Age 62

NOTE: Please review the plan summaries for more plan details. Earnings for LTD benefits are based on your base annual earnings and do not include other income such as bonuses and commissions.

Group Term Life and Accidental Death & Dismemberment (AD&D)

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump payment if you pass away while employed by Sharon Community School. As an eligible employee, you are covered for Group Term Life and AD&D insurance at no cost to you.

Sharon Community School offers a Group Term Life Insurance benefit of 1 x Annual Salary up to \$200,000, plus accidental death and dismemberment insurance coverage. Specific details of the plan are covered in the Plan Certificate.

Carrier Name Plan Highlights

Premium	Sharon Community School pays this premium at 100%
Amount of Life Insurance Benefit	1 x Annual Salary up to \$200,000
Amount of AD&D Benefit	Equal to term life

Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 70, to percent at age 75, and to 30 percent at age 80. Please see a representative from HR with any questions.

Mental Health Resources

Employee Assistance Program (EAP)

Life doesn't always go as planned. From time to time, we may face personal, financial, legal, or other issues which can negatively affect our mental well-being. In these situations, our stress often transfers to the ones who matter most, our family members. That's why Sharon Community School has partnered with The Standard to provide short-term counseling and support services.

Sharon Community School offers this benefit to you and your immediate family members at no cost. To access services, simply call The Standard at 888-293-6948. A phone call allows you to establish an appointment with one of their counselors. Our EAP benefit offers up to 3 sessions per issue. In most situations additional services won't be needed. If other services are necessary, The Standard will facilitate a referral and those services will be paid according to your health plan coverage.

It should be noted that The Standard makes every effort to protect your privacy and ensure that your EAP service is completely confidential. Sharon Community School does not know who utilizes these services and we encourage you and your family to take full advantage of the benefits of our EAP.

Common Concerns

- Depression
- Legal issues
- Caring for aging parents
- Workplace stress
- Divorce
- Financial pressure
- Seeking child care
- Relationship issues

REQUIRED FEDERAL NOTICES

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

HIPAA 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.

Effective Date of Notice: July 1, 2023

Who will follow this notice:

This notice describes the health information practices of Sharon Community School (the “Plan”) and that of any third party that receives medical information from or for us to assist us in providing Dental and Flexible Spending Account benefits.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the “Rule”). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to **Sharon Community School** (“Plan Sponsor”) for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medical information if you are a member of the armed forces and this is required by military command authorities.

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us. All requests for amendment of your medical information must include a reason to support the requested amendment.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

You have the right to request an “accounting of disclosures,” where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of April 14, 2003.

To request an accounting of disclosures, address your request to the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan’s use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

To obtain a paper copy of this notice, contact the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

You have the right to be notified following a breach of unsecured protected health information.

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your Plan Administrator Jenny Skemp, Payroll/Benefits, at 262.394.4502 or jenske@sharon.k12.iwi.us.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sharon Community School 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:

1. 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.
2. Sharon Community School has determined that the prescription drug coverage offered by MercyCare 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 to 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.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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 Sharon Community School coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Sharon Community School coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

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 Sharon Community School 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 Sharon Community School changes. You also may request a copy of this notice at any time.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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).

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private 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. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

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 are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our 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 self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the "minimum value"¹ standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – 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 ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can 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.

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.

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name: Sharon Community School
Employer Identification Number (EIN): 39-6004424
Employer Address: 104 E. School Street, Sharon, WI 53585
Employer Phone Number: 262.394.4502
Who can we contact about employee health coverage at this job? Phone Number (if different from above): Jenny Skemp Phone: 262.394.4502 Email address: jenske@sharon.k12.wi.us

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.
- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.
- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.
- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.
- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.
- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website:
<http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado

(Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program
(HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

CHIP (continued)

GEORGIA – Medicaid

A HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1 GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/> Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/> Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
<https://dhs.iowa.gov/ime/members> Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPI.PROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx> Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms> Phone: 1-800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/mashealth/pa>
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website:
<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website:
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP> Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov> Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov> Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

CHIP (continued)

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html> Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip> Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/> Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

CHIP (continued)

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

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